

**PERSONAL HISTORY**

Date: \_\_\_\_\_

Name (Last, First): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex:  Male /  Female Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single /  Married /  Significant Other /  Fiancée /  Divorced /  Separated /  Widowed

Name/Ages of Children \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Name & Phone \_\_\_\_\_

**EMPLOYMENT & INSURANCE INFORMATION**

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Type of Work \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Contract #: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Holders Name \_\_\_\_\_ S.S. # \_\_\_\_\_ D.O.B \_\_\_\_\_

Insurance Holders Work \_\_\_\_\_ Insurance Holders Work Phone \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Contract #: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Holders Name \_\_\_\_\_ S.S. # \_\_\_\_\_ D.O.B \_\_\_\_\_

Insurance Holders Work \_\_\_\_\_ Insurance Holders Work Phone \_\_\_\_\_

Who is responsible for your bill?  You /  Spouse /  Auto Insurance /  Workers' Comp /  Medicare /  Medicaid /  Other

**REFERRED**

**BY** \_\_\_\_\_

**CURRENT HEALTH HISTORY**

Chief Complaint \_\_\_\_\_

Date condition began: \_\_\_\_\_ Have you had this condition before?  YES /  NO When? \_\_\_\_\_

Name of Doctors seen for this condition \_\_\_\_\_

Treatment/Result \_\_\_\_\_

Is the condition:  Job Related /  Auto Accident /  Home Injury /  Fall /  Other (specify) \_\_\_\_\_

Have you reported this accident to:  Employer /  Auto Insurance /  Police /  Lawyer

Do you suffer from any condition other than that for which you are consulting us? \_\_\_\_\_

Current Prescription & Over the Counter Medications:

\_\_\_\_\_  
\_\_\_\_\_

**PAST HEALTH HISTORY**

**Surgeries**

- Appendectomy /  Broken Bone /  Back Surgery /  Gall Bladder /  Hernia /  Heart /  Prostate /  Tonsillectomy /  Vascular
- Other \_\_\_\_\_

**ACCIDENTS** \_\_\_\_\_

**HOSPITALIZATIONS** \_\_\_\_\_

**CHIROPRACTIC CARE HISTORY**

None / Doctors Name & Date of Last Visit \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE BEEN DIAGNOSED WITH:**

- |                                      |  |                                       |   |                                    |  |
|--------------------------------------|--|---------------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> H.I.V. +     | <input type="checkbox"/> Lumbalgia        | <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> Rubella           |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Measles          | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Hypotension  | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Polio     | <input type="checkbox"/> Whooping Cough    |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Influenza    | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Rheumatic | <input type="checkbox"/> NONE of the ABOVE |

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS:**

**NERVOUS SYSTEM**

- |                                      |   |  |                                      |  |
|--------------------------------------|---|--|--------------------------------------|--|
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Cold/Tingling Arms | <input type="checkbox"/> Depression    | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stress            |
| <input type="checkbox"/> Confusion   | <input type="checkbox"/> Cold/Tingling Feet | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Numbness    | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Paralysis   | <input type="checkbox"/> NONE of the ABOVE |

**MUSCULO-SKELETAL**

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Arm Pain R / L          | <input type="checkbox"/> Low back problems | <input type="checkbox"/> Neck Pain               | <input type="checkbox"/> Jaw Pain/Clicking   | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Disc (Bulge/Herniation) | <input type="checkbox"/> Mid back problems | <input type="checkbox"/> Shoulders(Pain between) | <input type="checkbox"/> Walking(Difficulty) | <input type="checkbox"/> NONE of the ABOVE |

**EYE, EARS, NOSE & THROAT**

- |   |   |                                      |                                       |  |
|---|---|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Ear Aches/Infections | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Vision Problems   |
| <input type="checkbox"/> Dental Problems      | <input type="checkbox"/> Menieres         | <input type="checkbox"/> Stuffy Nose | <input type="checkbox"/> Vertigo      | <input type="checkbox"/> NONE of the ABOVE |

**CARDIO- VASCULAR / RESPIRATORY**

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Ankle Swelling             | <input type="checkbox"/> Carotid Arteries | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Lung Congestion  | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Abdominal Aorta            | <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shortness Breath | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Blood Pressure(High / Low) | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Stroke           | <input type="checkbox"/> NONE of the ABOVE |

**GASTRO-INTESTINAL**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Abdominal Cramps  | <input type="checkbox"/> Black Bloody Stool | <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Vomiting (Frequent) |
| <input type="checkbox"/> Acid Reflux       | <input type="checkbox"/> Bloating/Gas       | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Hemorrhoids       | <input type="checkbox"/> Weight Problems     |
| <input type="checkbox"/> Appetite Decrease | <input type="checkbox"/> Colitis            | <input type="checkbox"/> Excessive Thirst  | <input type="checkbox"/> Liver Problems    | <input type="checkbox"/> _____               |
| <input type="checkbox"/> Appetite Increase | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Gall Bladder      | <input type="checkbox"/> Nausea (Frequent) | <input type="checkbox"/> NONE of the ABOVE   |

**GENITO-URINARY**

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> Bladder Trouble   | <input type="checkbox"/> Menstrual Cramps       | <input type="checkbox"/> Prostate            | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Urination-Excessive    |
| <input type="checkbox"/> Breast Pain/Lumps | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Urine Discoloration | <input type="checkbox"/> Urination-Painful  | <input type="checkbox"/> Vaginal Pain/Infection |
| <input type="checkbox"/> NONE of the ABOVE |   |  |   |   |

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**GENERAL**

Allergies      Fatigue      Fever      Headaches      Insomnia      \_\_\_\_\_      NONE of the ABOVE

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**FEMALES ONLY**

Date of last menstrual period\_\_\_\_\_

Are you pregnant? YES / NO / NOT SURE

**MALES ONLY**

Date of last prostate exam\_\_\_\_\_

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**LIFESTYLE**

Smoke \_\_\_\_\_packs/day      Alcohol Beverages/week\_\_\_\_\_      Caffeinated Coffee \_\_\_\_\_cups/day      Diet Soda \_\_\_\_\_amount/day  
Soda \_\_\_\_\_amount/day      Exercise\_\_\_\_\_days/week

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**PERSONAL/FAMILY HISTORY**

Autoimmune	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
High BP	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
Low BP	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
Cancer	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
Diabetes	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
Heart Disease	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
Stroke	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent
Other	Self / Mother / Father / Sibling / Maternal Grandparent / Paternal Grandparent

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ANY OTHER HEALTH CONCERNS NOT INCLUDED ABOVE – PLEASE WRITE HERE.

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**DO NOT WRITE BELOW THIS LINE**

Doctors Notes:

Examining Doctors Signature:\_\_\_\_\_

**TERMS OF ACCEPTANCE CHIROPRACTIC INFORMED CONSENT**

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for both of us to be working towards the same objective.

Chiropractic only has one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment,

**ADJUSTMENT:** An ADJUSTMENT is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

**HEALTH:** Health is a state of optimal physical, mental, and social well being not merely the absence of disease or infirmity.

**VERTREBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in lessening of the body's God given innate ability to express its maximum health potential.

We do not diagnose or treat any diseases or conditions other than vertebral subluxation; however, if during the course of a spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or previous chiropractor may have discussed with you various modalities of pain relief such as drugs, physical therapy, manipulation, surgery, etc. We want to make you aware of how care works in this office and what is available today, thanks to progress in spinal health care.

**ADULTS:** Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

**CHILDREN:** Children's spines are very fragile and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore it is best to check children for subluxation and begin any necessary treatment as young as possible.

**DURATION OF CARE:** While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, severity of subluxation and lifestyle, adjustment and rehabilitation schedule for correction care can range from six months to two years. Following correction, the doctor will make the recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive chiropractic results. Thus, the following information is routinely supplied to all who consider chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that like all other areas of the healing arts, response to treatment and results cannot be guaranteed.

**FAMILY CHECK UP:** Spinal conditions are often silent and go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check up to discover whether significant spinal health issues exist.

**CORRECTIVE CARE:** Tremendous progress has been made in rehabilitation and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline your course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

**WELLNESS CARE:** Spinal neglect is so common. It has become an epidemic in our society despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then maintain this for a lifetime.

**CONSENT**

\_\_\_\_\_, have read and full understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Signature Date

**CONSENT TO EVALUATE AND ADJUST A MINOR CHILD**

\_\_\_\_\_, being a parent/legal guardian of \_\_\_\_\_, I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Signature Date

**PREGNANCY RELEASE**

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her special associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. DATE OF LAST MENSTRUAL PERIOD\_\_\_\_\_

\_\_\_\_\_  
Date Signature