

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? ___ Do you smoke? ___ If so, packs per day: _____
Do you take vitamin supplements? ___ If so, please list: _____
Do you consume caffeine? ___ If so, how much per day: _____
Do you exercise? ___ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting ___ sitting ___ bending ___ working at a computer _____

FAMILY HISTORY:

Parents:
Father: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if deceased: _____ (check one)
Mother: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if deceased: _____ (check one)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis ___ Cancer ___ Mental Illness ___
Diabetes ___ Asthma ___ Heart Disease ___
Stroke ___ Kidney Disease ___ Lung Disease ___
Arthritis ___ Liver Disease ___
Other _____

Please check any and all insurance coverage that may be applicable in this case:
Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

SUMMARY

- 1. What is your major symptom? _____
- 2. What does this prevent you from doing or enjoying? _____
- 3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
- 4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
- 5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No _____. If yes, describe: _____
Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____

- 6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
- 7. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____

- 8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
- 9. List any major accidents you have had other than those that might be mentioned above: _____

- 10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
- 11. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____