Patient Name_____ Date_____

Reason for today's visit: ☐Emergency ☐ New Injury ☐Old Injury ☐Chronic Pain

Are you in pain: ☐Yes ☐No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐ Work ☐ Sports/play ☐ Auto Accident ☐ Daily routine/or activity?
If so, how: _____

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Please explain what happened:_____
Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine? If so, how:

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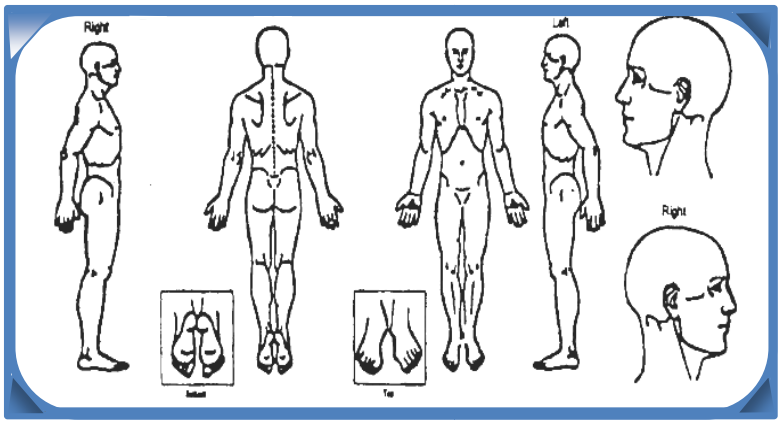
Has this or something similar happened in the past?
☐ Yes ☐ No Explain: _____
_____

Using the adjacent body charts, please circle all affected areas.
Have you been treated by a medical physician for this Pain?
☐ Yes ☐ No If so, where? _____
_____




Have you ever been treated by a chiropractor? ☐ Yes ☐ No Clinic/Doctors name: _____

How long ago? _____

Are you taking any medications? ☐ YES ☐ NO

If YES please list medication: _____

Do you have or have you had any diseases, medical conditions, surgeries or procedures? Please list them;

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***Please tell us who referred you to our office so that we may thank them:*** _____

Patient Name_____ Date_____

Family Health History:

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Do you take Supplements or Vitamins? ☐ Yes ☐ No Do you exercise? ☐ Yes __ Hours per week ☐ No
Do you smoke? ☐ Yes ☐ No How much? ____ How many years? _____

Are you wearing: ☐ Shoe lifts ☐ Arch supports ☐ Inner Soles

Are you dieting? ☐ Yes ☐ No Since __/__/__ Which diet are you using? _____

For Women: Are you taking Birth Control? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

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- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

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Signature _____ Date ___/___/___

☐ Adult patient ☐ Parent or Guardian ☐ Spouse