

GENERAL INFORMATION

Patient # _____ Phone # _____ Cell # _____ Work # _____

Name (Last, First, MI) _____ E-mail _____

Address _____

City/State/Zip _____

DOB ____/____/____ Age _____ Sex: M F Height: _____ Weight: _____

Employer: _____ Type of Work: _____

SS # _____ Spouse _____ # of Children _____

Names/Ages of Children _____

Referred to This Office By: _____ Relation To Patient _____

Primary Ins. _____ Secondary Ins. _____

CASE HISTORY

Major Concern: _____

How Has This Condition Affected Your Life/What Has It Kept You From Doing? Working Good Home Life
 Sports/Hobbies Spending Quality Time with Family Driving Other _____

Purpose Of This Appointment: _____

Would You Like to be: HEALTHY SYMPTOM-FREE JUST NOT SICK

How Would You Rate YOUR HEALTH RIGHT NOW? (1 = worst, 10 = best) 1 2 3 4 5 6 7 8 9 10

If Disabled From Work, Please Give Dates: _____

Medications You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Insulin
 Aspirin/Similar Other _____

Major Surgery/Operations: Appendix Tonsils Gall Bladder Hernia Heart Back
 Neck Leg Other _____

Major Accidents or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: Dr. Name and Approx. Date of Last Visit: _____

Date of Last Examination: _____ Have You Been Treated For Any Conditions in the Past Year? Yes No

If Yes, Please Explain: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Whooping Cough |

INTAKE	AMOUNT
<input type="checkbox"/> Coffee	_____
<input type="checkbox"/> Tea	_____
<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Cigarettes	_____
<input type="checkbox"/> Soda/Pop	_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation

NERVOUS SYSTEM

- Nervous
- Numbness/Tingling
- Paralysis
- Dizziness
- Forgetfulness
- Convulsions
- Cold/Tingling Extremities
- Stress
- Heartburn

FEMALES ONLY:

When was your last period? _____
Are you pregnant? Yes No Not Sure

C-V-R

- Chest Pain
 - Lung Problems
 - Blood Pressure Problems
 - Heart Problems
 - Stroke
- ### GENITO-URINARY
- Bladder Trouble
 - Painful/Excessive Urination
 - Discolored Urine

EENT

- Vision Problems
 - Dental Problems
 - Sore Throat
 - Ear Aches
 - Hearing Difficulty
- ### GENERAL
- Fatigue
 - Allergies
 - Loss of Sleep
 - Headaches
 - Fever

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that The Chiropractic Experience will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and adjustment plan, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor of Chiropractic to adjust my vertebral subluxations as he deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Signature X _____ Date _____

Guardian or Spouse Authorizing Care _____ Date _____

AUTO ACCIDENT INFORMATION

Patient Name _____ Date _____

Date and time of accident: _____ a.m. p.m.

Were you the: Driver Front Passenger Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to who was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing a seat belt? Yes No

Was this vehicle equipped with airbags? Yes No

If yes, did it/ they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below At base of skull

What did your vehicle impact? Another vehicle Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes No

If yes, please describe: _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? N S E W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: Front Rear Right Side Left Side Other

During impact, were you facing: Right Left Forward

Were you aware or surprised by the impact?

If accident vehicle made impact with another vehicle...

Direction other vehicle was headed? N S E W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

After Injury

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S.

Describe any treatment you received: _____

Were X-Rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tension | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Arms/ shoulder pain | <input type="checkbox"/> Numb hands/fingers | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Back pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Numb feet/ toes | <input type="checkbox"/> Leg Pain |

Other _____

Is your condition getting worse? Yes No Constant Comes and goes

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent 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 adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease and infirmity.

Vertebral 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, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the 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 innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questioning regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)