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Date: ____/_____/_____ Patient # _____

Soc. Sec # ____/_____/_____ Case # _____

Patient Name: _____ Birth date _____/_____/_____ Age _____ Sex: M ___/F___

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: (_____) _____

Cell #: (_____) _____ Marital Status: S _____/ M_____/ W_____/ D_____/ # of children: _____

Names & ages of children under 16: _____

Parent/Guardian (if patient is a child): _____ Birth date _____/_____/_____

Address: _____ Phone: (_____) _____Soc. Sec # ____/_____/_____

Patient/parent Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____ ext. _____

Work City: _____Work State/Zip:_____WebPage:_____

Spouse/Contact:_____Birth date _____/_____/_____ Soc. Sec # ____/_____/_____

Spouse's Occupation: _____ Employer**:** _____

Work Address: _____ Work Phone: _____ ext. _____**Cell:**_____

Work City:_____Work State/Zip:_____E-Mail:_____

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PAYMENT IS EXPECTED AT TIME OF VISIT*

I, the undersigned, understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Chiropractic office will prepare any necessary form and reports needed to assist me in making collections from the insurance carrier, but, it is my responsibility to furnish this office with current information in order to instigate a claim. Until such information has been furnished by myself and verified to be correct by this office all charges are to be handled on a cash basis. Once coverage has been verified I agree to make payments for any unmet deductible amounts and the co-payment portion of each day's charges (as is detailed in my insurance policy). Any benefits authorized to be paid by my insurance carrier directly to this Chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me to that point will be immediately due and payable by me, personally.

Patient's Signature: _____ Date: _____/_____/_____

Guardian/Spouse's Signature (authorizing care): _____

*unless prior financial arrangements have been made.

PLEASE CONTINUE TO PAGE 2

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the Patient Health Questionnaire on the next page. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

Present Complaint: _____

_____

When did your problem begin? SPECIFIC DATE IF POSSIBLE: _____

Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time

Describe how your problem began: _____

_____

What treatment have you received for this present condition? (SPECIFIC DATE &TYPE OF TREATMENT WITH RESULTS) _____

_____

Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No. If yes by: ☐ Chiropractor ☐ MD

☐ Therapist ☐ Other _____ (SPECIFIC DATE &TYPE OF TREATMENT WITH RESULTS) _____

_____

Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS) ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull
☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

How often are the complaints present? ☐ Constant, (76-100%) ☐ Frequent, (51-75%) ☐ Intermittent, (26-50%)
☐ Occasional, (25% or less).

How bad is your pain or ache? Please circle a number: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise
☐ Inactivity ☐ Other _____

What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise
☐ Inactivity ☐ Other _____

How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

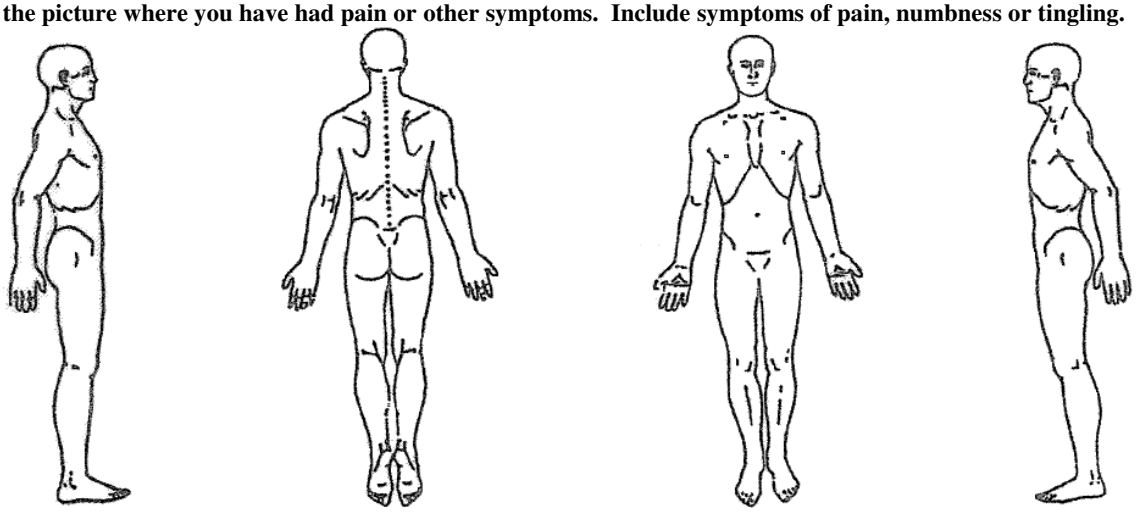
General physical activity: ☐ No regular Exercise Program ☐ Light Exercise Program ☐ Strenuous Exercise Program

Physical activity at work: ☐ Sedentary More than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor
☐ Heavy Manual Labor

Are your complaints affecting your ability to work or otherwise be active?
☐ No effect. ☐ Some physical restrictions (able to perform light duty work and household tasks).
☐ Need limited assistance with common everyday tasks. ☐ Need assistance often.
☐ Have a significant inability to function without assistance. ☐ Am totally disabled (impaired). Cannot care for self.

Mark an X on the picture where you have had pain or other symptoms. Include symptoms of pain, numbness or tingling.

A = Aching
B = Burning
S = Stabbing
N = Numbness
T = Tingling



PLEASE CONTINUE TO PAGE 3

PATIENT HEALTH QUESTIONNAIRE

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body symptom. If you have ever *had* a listed symptom in the *past*, please check that symptom in the *Past column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*.

Past	Present		Past	Present	
☐	☐	Neck Pain	☐	☐	Menopausal Symptoms
☐	☐	Shoulder Pain	☐	☐	Painful Urination
☐	☐	Pain in Upper Arm or Elbow	☐	☐	Loss of Bladder Control
☐	☐	Hand Pain	☐	☐	Frequent Urination
☐	☐	Upper Back Pain	☐	☐	Abdominal Pain
☐	☐	Low Back Pain	☐	☐	Difficulty in Swallowing
☐	☐	Pain in Upper Leg or Hip	☐	☐	Heartburn/Indigestion
☐	☐	Pain in Lower Leg or Knee	☐	☐	Constipation
☐	☐	Pain in Ankle or Foot	☐	☐	Rash
☐	☐	Jaw Pain	☐	☐	Dermatitis or Eczema
☐	☐	Swelling of Joints (Specify Joints)	☐	☐	Persistent Itching
		_____			
☐	☐	Stiffness of Joints (Specify Joints)			Please check any of the following that apply to you.
		_____			
☐	☐	Depression	☐	☐	Tobacco use
☐	☐	Fainting	☐	☐	Alcohol use
☐	☐	Convulsions	☐	☐	Medications (please list them)
☐	☐	Dizziness	☐	☐	_____
☐	☐	Headache	☐	☐	_____
☐	☐	Muscular incoordination	☐	☐	_____
☐	☐	Tinnitus (Ear Noises)	☐	☐	Drug or Alcohol Abuse
☐	☐	Rapid Heart Beat	☐	☐	Pregnancy
☐	☐	Chest Pains	☐	☐	Surgical Procedures (list them)
☐	☐	Loss of Appetite	☐	☐	_____
☐	☐	Abnormal Weight Gain	☐	☐	_____
☐	☐	Abnormal Weight Loss	☐	☐	_____
☐	☐	Chronic Cough	☐	☐	Coffee/Tea/Caffeinated
☐	☐	Chronic Sinusitis			soft drinks, cups per day _____

PRESENT: WEIGHT _____pounds
HEIGHT _____feet _____ inches

Yes	No	
☐	☐	Do you have a permanent disability rating?

Date rating received _____/_____/_____
Rating Percentage _____%

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present		Past	Present	
☐	☐	Hemorrhoids	☐	☐	Emphysema
☐	☐	Rheumatic Heart Disease	☐	☐	Arthritis
☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Angina	☐	☐	Ulcer
☐	☐	Heart Attack	☐	☐	Kidney Stones
☐	☐	Stroke	☐	☐	Bladder Infection
☐	☐	Asthma	☐	☐	Other _____
☐	☐	Cancer	☐	☐	_____
☐	☐	Prostitis	☐	☐	_____