α CHIROPRACTIC FIRST

PLEASE PRINT CLEARLY AND FILL IN ALL BLANKS

Print Name _____ Date _____

Street/Mailing Address _____ City _____

State _____ Zip Code_____ Email Address _____

Cell Phone _____ Cell Phone Provider _____

Home Phone _____ Office Phone _____

Date of Birth _____ Sex _____ Married ◯ Single ◯

Social Security # _____ Spouse _____

Occupation _____ **Referred by** _____

CHIROPRACTIC HISTORY

Have you been to a Chiropractor before? Yes ◯ No ◯

If yes, Doctor's name _____ Reason for care _____

Date of last visit? _____ Date of last x-ray? _____ How long under care? _____

Are any other family members under Chiropractic Care? Yes ◯ No ◯

HEALTH HISTORY

Give reason for seeking care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

List any past surgeries and dates: _____

List any past accidents and dates: _____

List any x-rays you've had in the past 2 years: _____

Have you ever had any broken bones/fractures: _____

Please list any **medications** you currently take, the dosage, frequency, what it's for and how long you've been taking each: _____

_____

_____

_____

_____

_____

Do you take any vitamins/supplements? Yes ◯ No ◯
If yes what kind? _____

FEMALES ONLY Is there a possibility of you being pregnant? Yes ◯ No ◯

Please check **YES OR NO** on all of the following health concerns, even if you do not think that your answers relate to you or your present health.

Allergies	Yes ◯ No ◯	Heart Condition	Yes ◯ No ◯
Anxiety	Yes ◯ No ◯	Immune System Disorder	Yes ◯ No ◯
Arthritis	Yes ◯ No ◯	Infertility	Yes ◯ No ◯
Asthma	Yes ◯ No ◯	Kidney Disease	Yes ◯ No ◯
Back Pain	Yes ◯ No ◯	Menstrual Cramps/Problems	Yes ◯ No ◯
Bladder Problems	Yes ◯ No ◯	Mood Swings	Yes ◯ No ◯
Cancer	Yes ◯ No ◯	Neck Pain	Yes ◯ No ◯
Circulatory/Vascular Disorder	Yes ◯ No ◯	Numbness/Tingling	Yes ◯ No ◯
Depression	Yes ◯ No ◯	Osteoporosis	Yes ◯ No ◯
Diarrhea/Constipation	Yes ◯ No ◯	Sinus Trouble	Yes ◯ No ◯
Digestive Problems	Yes ◯ No ◯	Skin Conditions	Yes ◯ No ◯
Dizziness	Yes ◯ No ◯	Sleep Challenges	Yes ◯ No ◯
Headaches	Yes ◯ No ◯	Urinary Difficulty	Yes ◯ No ◯
Heartburn/Reflux	Yes ◯ No ◯	Vertigo	Yes ◯ No ◯
		Other _____	

STRESS HISTORY

Please indicate whether you have **EVER** experienced stress in any of the following areas **during your childhood and adulthood** by marking a **YES OR NO**. Your answers will enable us to **determine which factors have contributed** to your present health concerns.

Repeated/Prolonged Antibiotic Use	Yes ◯ No ◯	Youth Sports	Yes ◯ No ◯
Car Accident	Yes ◯ No ◯	Contact Sports	Yes ◯ No ◯
Childhood Illness	Yes ◯ No ◯	Extreme Sports	Yes ◯ No ◯
Fall/Jump from a height < 3 feet	Yes ◯ No ◯	Coffee Drinks	Yes ◯ No ◯
Fall/Jump from a height > 3 feet	Yes ◯ No ◯	Home Environment Stress	Yes ◯ No ◯
Head Trauma	Yes ◯ No ◯	Workplace Stress	Yes ◯ No ◯
Inhaler Use	Yes ◯ No ◯	Alcohol Consumption	Yes ◯ No ◯
Prescription Medication	Yes ◯ No ◯	Drug Use/Abuse	Yes ◯ No ◯
Surgery	Yes ◯ No ◯	Smoking	Yes ◯ No ◯
Vaccination	Yes ◯ No ◯	Other Traumas (Physical/Emotional) _____	
		_____	

LIFESTYLE INFORMATION

Do you exercise? Yes ◯ No ◯ If yes, how much and how often? _____

Do you use tobacco? Yes ◯ No ◯ If yes what type and how often? _____

Do you consume alcohol? Yes ◯ No ◯ If yes, how much and how often? _____

Do you drink soft drinks? Yes ◯ No ◯ Diet or Regular? How Much? _____

Do you drink water? Yes ◯ No ◯ If yes how much? _____

Do you drink coffee? Yes ◯ No ◯ If yes how much? _____

How would you rate your nutritional habits? Great ◯ Good ◯ Fair ◯ Poor ◯

How many hours of sleep do you usually get? _____ Is the quality of sleep Good ◯ Fair ◯ Poor ◯

Stress level (personal): Low ◯ Medium ◯ High ◯

Stress level (at work): Low ◯ Medium ◯ High ◯

What do you do to relieve or handle your stress? _____

ASSIGNMENT AND RELEASE

We accept payment by cash, check and credit card

Who is responsible for this account? _____

Relationship to Patient _____

I, the undersigned, hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that all services are to be **paid in full at the time of service**, unless other arrangements have been made and agreed upon in writing. I certify that all information is filled out accurately to the best of my knowledge.

_____

Responsible Party Signature Date Relationship to Patient

_____

Patient Signature Date