ABOUT YOU				
First Name	Middle Name			
Last Name				
Address Line 1				
Address Line 2				
City State	ZIP Code			
Mobile Phone Work Phone	Home Phone			
Email				
Date of Birth / /	Gender □ Male □ Female			
Height"	Weight lbs			
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other				
Number of Children	Spouse's Name			
EMERGENCY CONTACT INFORMATION.				
Name				
Phone	Relation To You			

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INSURANCE INFORMATION						
Do you have Insurance?		□ Yes □ No				
Insurance Name			Phone			
Address Line 1						
Address Line 2						
City	State		ZIP Code			
ID/Policy Number		Group Number				
Insured's Name		Insured's Date of Birth	//			
REFERRAL INFORMATION.						
Referring Physician		Contact information.				
Referring Patient						
Are you working with an attorney?		□ Yes □ No				
How did you hear about us? ☐ Word of mouth ☐ Advertisement ☐ Social	media	□ Direct marketii	ng ⊏ Internet			

R	REASON FOR VISIT
What is the date of your scheduled appointment?	11
How long have you had this complaint?	□ Less than 5 days (Acute) □ Between 5-30 days (Sub Acute) □ More than 30 days (Chronic)
What caused this condition	
What is the date this condition began? (Skip if due to accident)	
What term(s) describes your discomfort best?	
On the body diagrams to the right, ple indicate your areas of symptoms by dependent of the appropriate symbols. P - pain N - numbness W - weakness S - shooting A - Aching	
On a scale of 1 to 10, with 10 being the	e most severe, how do you rate your discomfort?
None 0 1 2 3	Unbearable 5 6 7 8 9 10
How often do you feel this discomfort	? □ Constant □ Frequent □ Occasional □ Intermittent
How has this complaint changed since the onset?	^e □ Worsened □ Remained the same □ Improved
What activity is most significantly affected by this discomfort? (Explain)	
What treatment, if any, have you received since the injury?	

Page 4 of 6 What aggravates this condition?	
What improves this condition or gives you relief?	5
Have other health care provider(s) performed tests related to this condition?	
Have you ever had any previous episodes of this condition?	
	CURRENT HEALTH
Other than the information already p	provided, do you have additional health concerns involving any of the following?
Muscles, Bones or Joints	□ No □ Yes Explain:
Nerves, Headaches, Dizziness, or Emotional	□ No □ Yes Explain:
Head, Eyes, Ears, Nose or Throat	□ No □ Yes Explain:
Heart, Blood Pressure, or Circulation	□ No □ Yes Explain:
Shortness of Breath, Coughing, Asthma or Lung Condition	□ No □ Yes Explain:
Stomach, Bowels or Digestive Conditions	□ No □ Yes Explain:
Genital, Bladder, or Urinary Conditions	s⊓No⊓Yes Explain:
Diabetes, Thyroid or Glandular Conditions	□ No □ Yes Explain:
Skin or Bleeding Conditions	□ No □ Yes Explain:
Do you have any medication allergies?	□ No □ Yes Explain:

PERSONAL AND FAMILY HISTORY Have you had any surgical □ No □ Yes Explain: _____ procedures? Are there any past illnesses or □ No □ Yes Explain: conditions we should be aware of? Do you have a past history of □ No □ Yes Explain: _____ accidents or trauma? Are you presently taking any □ No □ Yes Explain: medication? Do you have a past family illness □ No □ Yes Explain: history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?

WORK SOCIAL HABITS				
Current work habits - Choose all that apply.	☐ Permanently fully disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition ☐ Full-time (20-40+ hours/week) ☐ Part-time (1-19 hours/week) ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed			
Personal social habits - Choose all that apply.	☐ Smoke or use tobacco products ☐ Drink alcohol ☐ Drink caffeine ☐ Use recreational drugs ☐ Other, to be discussed with doctor			
Present exercise habits - Choose all that apply.	 □ No current exercises □ Exercises daily □ Exercises 3+ times per week □ Cannot return to exercise due to current condition 			
Diet and nutrition habits - Choose all that apply.	□ Vegan or vegetarian □ Daily supplements □ Other			

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _	 	 I	Date: _	/	/	