



Have you seen other doctors for this condition?  Yes  No If yes, who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Are you satisfied with the results of the treatment?  Yes  No

Primary Care Physician: \_\_\_\_\_ Have you ever had Chiropractic care before?  Yes  No

May we communicate with your Primary Care Physician about your care?  Yes  No

Do you exercise?  None  Infrequent  Regular  Frequent and Heavy

Sufficient rest  Never  Rarely  Occasionally  Moderately

Hours of sleep  3-4  5-6  7-8  9-10  More than 10

Personal stress  Low  Medium  High  Very high

Occupational stress  Low  Medium  High  Very high

Well balanced diet  Never  Rarely  Occasionally  Regularly

Do you smoke?  No  Occasionally  1 to 5  6 to 10  11-15  Packs per day?

Do you drink alcohol?  No  Occasionally  1 to 2  2 to 3  4 to 5  More than 5 per day

Do you drink  No  Occasionally  1 to 2  2 to 3  4 to 5  More than 5 per day  
caffeine?

## Secondary Complaint and Location

Secondary Complaint: \_\_\_\_\_

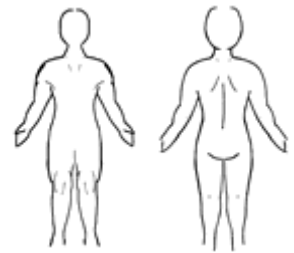
When did your symptoms appear (Onset Date)? \_\_\_\_\_

Please describe the cause of the injury: \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_



Please describe your symptoms:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Shooting	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Crawling	<input type="checkbox"/> Pulsating
<input type="checkbox"/> Dull	<input type="checkbox"/> Burning	<input type="checkbox"/> Deadness	<input type="checkbox"/> Pins and Needles	<input type="checkbox"/> Prickly
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tingling	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Stinging	<input type="checkbox"/> Pounding
<input type="checkbox"/> Aching	<input type="checkbox"/> Cramping	<input type="checkbox"/> Numb	<input type="checkbox"/> Excruciating	

What makes it worse?

<input type="checkbox"/> Sitting	<input type="checkbox"/> Lifting	<input type="checkbox"/> Driving	<input type="checkbox"/> Looking Down	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Standing	<input type="checkbox"/> Coughing	<input type="checkbox"/> Walking	<input type="checkbox"/> Rotating Head	<input type="checkbox"/> Carrying
<input type="checkbox"/> Bending	<input type="checkbox"/> Straining	<input type="checkbox"/> Exercising	<input type="checkbox"/> Stress	<input type="checkbox"/> Climbing Stairs
<input type="checkbox"/> Lying Down	<input type="checkbox"/> Getting out of bed	<input type="checkbox"/> Looking Up	<input type="checkbox"/> Bright Lights	<input type="checkbox"/> Repetitive Movement

What makes it better?

<input type="checkbox"/> Ice	<input type="checkbox"/> Rest	<input type="checkbox"/> Pain Medications	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Exercising
<input type="checkbox"/> Heat	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Mineral Ice	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Anti-inflammatory
<input type="checkbox"/> Massage	<input type="checkbox"/> Advil	<input type="checkbox"/> Muscle Relaxers	Other: _____	

What time of day is it worse?  Morning  End of day  Night  Various Times

What percentage of the day is the condition present?  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation  None

## Third Complaint and Location

Third Complaint: \_\_\_\_\_

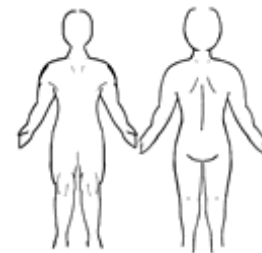
When did your symptoms appear (Onset Date)? \_\_\_\_\_

Please describe the cause of the injury: \_\_\_\_\_

Is this condition getting progressively worse?     Yes     No     Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_



Please describe your symptoms:

- |                                    |                                   |                                    |                                           |                                    |
|------------------------------------|-----------------------------------|------------------------------------|-------------------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp     | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Crawling         | <input type="checkbox"/> Pulsating |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Burning  | <input type="checkbox"/> Deadness  | <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Prickly   |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing  | <input type="checkbox"/> Stinging         | <input type="checkbox"/> Pounding  |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Cramping | <input type="checkbox"/> Numb      | <input type="checkbox"/> Excruciating     |                                    |

What makes it worse?

- |                                     |                                             |                                     |                                        |                                              |
|-------------------------------------|---------------------------------------------|-------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Sitting    | <input type="checkbox"/> Lifting            | <input type="checkbox"/> Driving    | <input type="checkbox"/> Looking Down  | <input type="checkbox"/> Sneezing            |
| <input type="checkbox"/> Standing   | <input type="checkbox"/> Coughing           | <input type="checkbox"/> Walking    | <input type="checkbox"/> Rotating Head | <input type="checkbox"/> Carrying            |
| <input type="checkbox"/> Bending    | <input type="checkbox"/> Straining          | <input type="checkbox"/> Exercising | <input type="checkbox"/> Stress        | <input type="checkbox"/> Climbing Stairs     |
| <input type="checkbox"/> Lying Down | <input type="checkbox"/> Getting out of bed | <input type="checkbox"/> Looking Up | <input type="checkbox"/> Bright Lights | <input type="checkbox"/> Repetitive Movement |

What makes it better?

- |                                  |                                  |                                           |                                     |                                            |
|----------------------------------|----------------------------------|-------------------------------------------|-------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Ice     | <input type="checkbox"/> Rest    | <input type="checkbox"/> Pain Medications | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Exercising        |
| <input type="checkbox"/> Heat    | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Mineral Ice      | <input type="checkbox"/> Sleeping   | <input type="checkbox"/> Anti-inflammatory |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Advil   | <input type="checkbox"/> Muscle Relaxers  | Other: _____                        |                                            |

What time of day is it worse?     Morning     End of day     Night     Various Times

What percentage of the day is the condition present?    10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

Does it interfere with your:     Work     Sleep     Daily Routine     Recreation     None

## Past Health History

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

### Neurological Health History

- |                                             |                                              |                                          |                                        |
|---------------------------------------------|----------------------------------------------|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Facial Weakness    | <input type="checkbox"/> Loss of Balance     | <input type="checkbox"/> Sensation Loss  | <input type="checkbox"/> Memory Loss   |
| <input type="checkbox"/> Smell Disturbance  | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Incontinence    | <input type="checkbox"/> Dizziness     |
| <input type="checkbox"/> Speech Disturbance | <input type="checkbox"/> Seizures _____      | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness   |
| <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Tension       |

### Musculoskeletal Health History

- |                                               |                                                    |                                           |                                        |
|-----------------------------------------------|----------------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Abnormal Posture     | <input type="checkbox"/> Disc Herniation           | <input type="checkbox"/> Osteopenia       | <input type="checkbox"/> Elbow Problem |
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Wrist Problem |
| <input type="checkbox"/> Dislocation/Fracture | <input type="checkbox"/> Shoulder Problem _____    | <input type="checkbox"/> TMJ Syndrome     | <input type="checkbox"/> Ankle Problem |
| <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> Knee Problem _____        | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Pes Planus    |
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Sprain/Strain _____       | <input type="checkbox"/> Tendonitis _____ | Other _____                            |

## Childhood Illnesses

- |                                              |                                                |                                      |                                            |
|----------------------------------------------|------------------------------------------------|--------------------------------------|--------------------------------------------|
| <input type="checkbox"/> ADD / ADHD          | <input type="checkbox"/> Allergies / Hay Fever | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Eczema            |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Depression  | <input type="checkbox"/> Diabetes (Type I) |
| <input type="checkbox"/> Fetal Drug Exposure | <input type="checkbox"/> Food Allergies        | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> Measles             | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Rash        | <input type="checkbox"/> Scoliosis         |
| <input type="checkbox"/> Sickle Cell Anemia  | <input type="checkbox"/> Ear infections        | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Bed Wetting       |

## Adult Illnesses

- |                                               |                                             |                                                    |                                              |
|-----------------------------------------------|---------------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Alzheimers           | <input type="checkbox"/> Anemia             | <input type="checkbox"/> CRPS (RSD)                | <input type="checkbox"/> Cancer _____        |
| <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Crohn's / Colitis  | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Kidney Problems     |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Diabetes (Type II) | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Eye Problems         | <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Parkinson's Disease       | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Seizure Disorder          | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Lupus Erythema       | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Vertigo                   | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Asthma                    |                                              |
| <input type="checkbox"/> Suicide Attempt(s)   | <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Ear Infections (frequent) |                                              |

## Past Surgeries

- |                                                 |                                        |                                                |                                               |
|-------------------------------------------------|----------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Angioplasty            | <input type="checkbox"/> Appendectomy  | <input type="checkbox"/> Ceaserian Section     | <input type="checkbox"/> Carpal Tunnel Repair |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Cosmetic      | <input type="checkbox"/> D & C                 | <input type="checkbox"/> Rotator Cuff         |
| <input type="checkbox"/> Hemorrhoidectomy       | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hysterectomy          | <input type="checkbox"/> Gallbladder          |
| <input type="checkbox"/> Laminectomy _____      | <input type="checkbox"/> Mastectomy    | <input type="checkbox"/> Pacemaker Insertion   | <input type="checkbox"/> Knee Replacement     |
| <input type="checkbox"/> Spinal Fusion _____    | <input type="checkbox"/> Tympanostomy  | <input type="checkbox"/> Cardiac Catherization | <input type="checkbox"/> Hip Replacement      |
| <input type="checkbox"/> Other _____            |                                        |                                                |                                               |

## Current Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

## Vitamins and Supplements

_____	_____	_____
_____	_____	_____
_____	_____	_____

## Known Drug Allergies

_____	_____	_____
_____	_____	_____

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:*

\_\_\_\_\_  
*Signature (Patient or Guardian)*

\_\_\_\_\_  
*Date*

## Financial / Insurance Information

Who is responsible for this account? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Health Insurance Company Name: \_\_\_\_\_ 2<sup>nd</sup> Ins. Co. Name: \_\_\_\_\_

Please be aware of the following: If you have an HMO, you will need a referral from your Primary Care Doctor. Also, some plans require a Pre-Authorization after the Initial Exam and Report of Findings.

### Denial of Work/Auto Accident

I confirm that the treatment I am requesting to receive today is NOT for injuries sustained in an automobile accident or work-related accident.

\_\_\_\_\_  
*Signature (Patient or Guardian)*

\_\_\_\_\_  
*Date*

### Auto Accident Information

If you were in a Motor Vehicle Accident, please list YOUR Auto Insurance information:  
(We do not bill 3<sup>rd</sup> Party Automobile Insurance Companies. See MVA Financial Policies Page for details.)

Auto Insurance Company Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_ Phone # \_\_\_\_\_

### Financial Policies / Fee Schedule

I understand that health and accident policies are an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collections from my insurance company. **Ultimately, I am responsible for all services rendered, including those not reimbursed by my insurance company.**

#### Services

Initial 5-minute Consultation

New Patient Exam

X-Rays, 2-3 view, 1 area

Interim/Update Examination

Care Coordination and Counseling

Chiropractic Adjustment

Interferential Stimulation Therapy

Intersegmental Traction Therapy

Therapeutic Exercises/Rehab

MLS Cold Laser (per body area)

Non-Surgical Spinal Decompression

Kinesio Taping

#### Fees

Complimentary

\$100.00

\$65.00

\$60.00

\$40.00

\$50.00

\$25.00

\$25.00

\$35.00

\$65.00

\$75.00

\$15.00

*I have read and understand the above financial policies.*

\_\_\_\_\_  
*Signature (Patient or Guardian)*

\_\_\_\_\_  
*Date*