

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

Second Complaint/Body Area: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

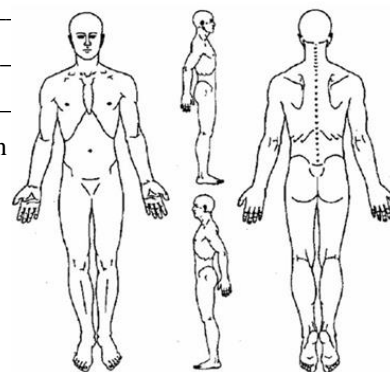
Is this condition getting progressively worse? Yes No Unknown

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"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Deadness |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Cramping | <input type="checkbox"/> Numb |
| | | <input type="checkbox"/> Excruciating |
| | | <input type="checkbox"/> Pulsating |



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/Body Area: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

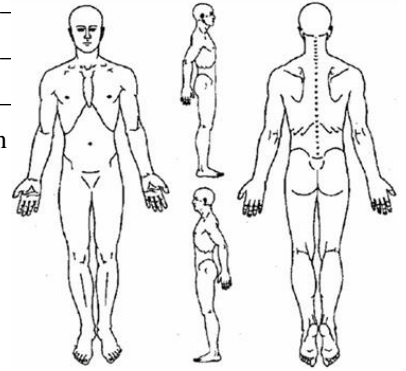
Is this condition getting progressively worse? Yes No Unknown

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"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Deadness |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Cramping | <input type="checkbox"/> Numb |
| | | <input type="checkbox"/> Excruciating |
| | | <input type="checkbox"/> Pulsating |



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"/> Alzheimer's	<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: _____ 2nd 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 3rd 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

Progress Exam

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

\$55.00

\$25.00

\$25.00

\$40.00

\$65.00

\$75.00

\$20.00

I have read and understand the above financial policies.

Signature (Patient or Guardian)

Date