Today's Date ____/____/____ File Number_____-_____

Name: _____ What You prefer To Be Called _____ Spouse Name_____

Address: _____ City: _____ Zip: _____ □ S □ M □ D □ W

SS#: _____/____/_____ Birth Date:____/____/____ Age: ____ □ Male □ Female # Children _____

Home Phone: _____ Work Phone: _____

E-Mail: _____ Cellular: _____

Employer: _____ Occupation: _____

Insurance Company: _____

Policy Holder: □ Self □ Spouse □ Other _____

If Spouse Name: _____ Spouse DOB: ___/____/____

□ Headache □ Neck Pain □ Arm/Hand Pain □ Shoulder Pain □ Mid-Back Pain □ Low Back Pain □ Leg/ Foot Pain □ Arthritis □ Disc Herniation □ Sport Injuries □ Work Injuries □ Auto Accidents □ TMJ □ Other

□Wellness Care/ Maintenance Care

Please list condition from worst to least. Is it getting worse? □Yes □ No

1. _____ 2. _____ 3. _____

What Happen/Start Date? _____

Severity: □ Mild □ Mild to Moderate □ Moderate □ Moderately Severe □ Severe

General Symptoms and Problems

□ Cancer _____	□ Weakness	□ Strokes: Year_____	□ Painful Urination
□Diabetes	□ Colon Trouble	□ Deafness	□ Difficult Breathing
□Loss of Sleep	□ Constipation	□ Hyper/Hypo Thyroid	□ Chronic Cough
□Neuralgia	□ Stomach Pain	□ Nose Bleeds	□ Swelling: _____
□Hernia	□ Vomiting Blood	□ Chest Pain	□ Cramps/Backaches
□Osteoporosis	□ Heart Disease	□ Spitting Blood	□ Miscarriage: Year_____
□Scoliosis	□ High/Low Blood Pressure	□ Blood in Urine	□ Currently Pregnant
□Tremors/Twitching	□ Allergies: _____	□ Inability to Control Urine	□ Other: _____

Family History:

Mother □ Diabetes □Heart □Kidney □Cancer □Back

Father □ Diabetes □Heart □Kidney □Cancer □Back

Brother □ Diabetes □Heart □Kidney □Cancer □Back

Sister □ Diabetes □Heart □Kidney □Cancer □Back

Habits □Smoking □Drinking □ Coffee □Exercise □ Stress

Family Doctor?_____

Location:_____

Phone:_____

I have ever had any operations/surgeries_____

List any accidents or falls and dates: (Car, work, sports, etc.)_____

List any broken bones (fractures) or dislocations: _____

Have you ever had any spinal taps or spinal injection _____

Were you ever knocked unconscious? _____

Have you ever had a lapse of memory? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication-prescription or over-the-counter? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's 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 will be immediately due and payable. Hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis

_____ _____

Patient/ Guardian Signature Date:

Pain Drawing

Name:_____ Date:_____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

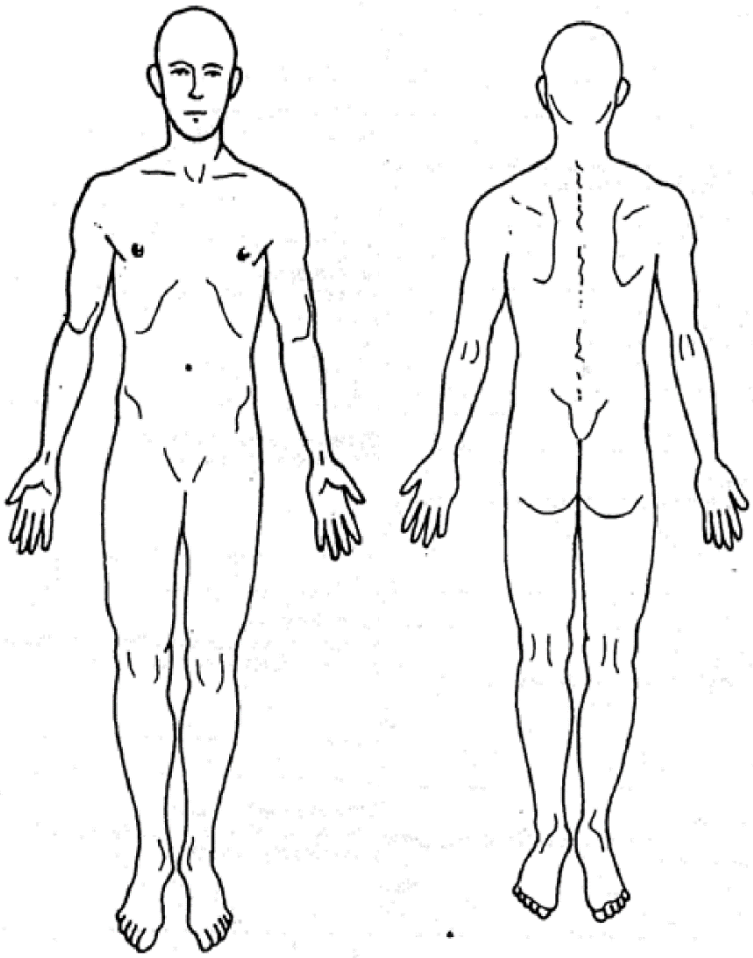
Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

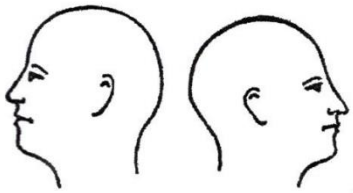
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~

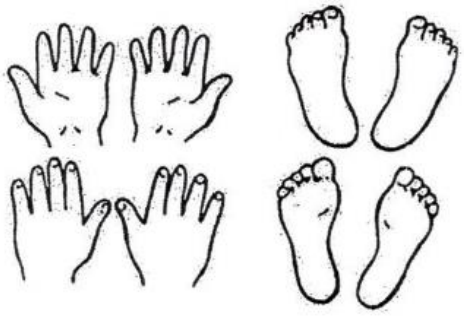
Pain Frequency: □ Intermittent 25% □ Occasional 50% □ Frequent 75% □ Constant 100%

Description of pain: □ Inflexibility □ Restricted Movement □ Stiff □ Excruciating □ Sharp □ Shooting

Is it Painful to: □ Walk □ Sit □ Stand □Bend □Lift □Lie Down □ Sleep □Other _____







Severity of Pain

List the region of pain.
Circle the severity number.
1=least pain, 10=greatest pain

ex: NECK
0 1 2 3 4 5 6 7 8 9 10

1. _____
0 1 2 3 4 5 6 7 8 9 10

2. _____
0 1 2 3 4 5 6 7 8 9 10

3. _____
0 1 2 3 4 5 6 7 8 9 10

4. _____
0 1 2 3 4 5 6 7 8 9 10

5. _____
0 1 2 3 4 5 6 7 8 9 10

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The Health Insurance Portability and Accountability Act is a law designed to provide standards for privacy to protect patients' medical records and other information provided to health plans, doctors, and other health care facilities. These standards provide patients with access to their medical records and gain control over how their personal health information is used and disclosed to others.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____ Today's Date ____/____/____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Who may we speak to regarding your Health: _____

Relationship: _____ Contact Number: _____

Labs and Report Information

Have you had any recent X-Rays, MRI, or Cat Scan? □ Yes □ No

If So, Where? _____

Approx. Date: _____

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Some Medical facilities require a release of medical records signed and faxed, you may be asked to fill one out upon request