Personal and Family Health History

Name ____
Date ____________________
Address ________________________________
City _________________ State ____ Zip ________
Phone: (H) ________________(C)________________
E-mail ______________________________________
Appointment Reminder:
(pick one) Text_____ Email_____
Date of Birth _______________ (Age ______)

How did you first hear about our office?
____
Social Security # ____________________________
Occupation __________________________________
Employer ____________________________________
Marital Status S M D W
Emergency Contact____________________________
Phone_________________________________

Insurance Information: Please provide a copy of your insurance card to the receptionist

Are you the primary insured? Y N
If NO, Insured's Name ____________________
Relationship to Insured - Spouse - Child - Other
Insured's Date of Birth ______ _____________
Insured's Social Security #_______ __________

Insured's Address: O same
____
City_________________State ____Zip _______
Insured Phone: _________________________
Insured E-mail:__________________________

Current Health Condition

Describe the reason for your visit today? ____
Pain or Problem started on: _______________________What happened? _______________________________
Secondary Complaint: ____
Other Health Conditions: ____
Women only: Most recent menstrual cycle: _________ Are you pregnant? Yes No Due date: ___________

Which best describes the frequency of your symptoms:
❒ Constant (76-100%) ❒ Frequent (51-75%) ❒ Intermittent (26-50%) ❒Occasional (0-25%)
Which best describes the changes in your symptoms?
❒ It is worse in the morning ❒ It is worse in the afternoon ❒ It is worse at night
❒ It changes with the weather ❒ It does not change
What helps relieve your symptoms? ❒ Ice ❒ Heat ❒Medication ❒ Nothing helps ❒ Other______________
What activities are limited by your symptoms?

- o Bending
- o Bowel movements
- o Coughing
- o Daily Routine
- o Driving
- o Getting up
- o Lifting
- o Lying down
- o Pulling
- o Pushing
- o Reading
- o Sitting
- o Sleeping
- o Sneezing
- o Standing
- o Turning head
- o Urinating
- o Walking
- o Working
- o Other: ____________

Have you tried other treatments for this condition? Yes No Name of Dr./Provider _______________________
Have you been to a chiropractor before? Yes No Name of Dr. _______________________________
Primary Care Physician: ____
What medications are you taking? ____
Please specify the approximate day of your most recent:
X-ray _____________ MRI _____________ Surgery ____________ Physical Exam __________________
Is this condition getting progressively worse? Yes No
Is this a Work Injury? Yes No Have you reported the injury to your employer? Yes No
Is this a Car Accident? Yes No Has a police report been filed? Yes No
Have you lost any time from work as a result of your accident? Yes No

Circle all that Apply:

Smoke? Y N — Drink Alcohol? Y N

Exercise regularly? Y N — Do you have stress? Y N Work Physical Mental

How old is your mattress? ________ years — How old is your pillow? _________years

Other symptoms:

- o Nervousness/anxiety
- o Chest Pains
- o Dizziness/Vertigo
- o Pins & Needles
- o Numbness
- o Shortness of Breath
- o Fatigue
- o Depression
- o Ears Ring/Buzz
- o Loss of Smell/Taste
- o Diarrhea
- o Constipation
- o Loss of Balance

Family History:	Heart Disease	Arthritis	Cancer	Diabetes	Other ________________
Do you have	❒	❒	❒	❒	❒
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

I hereby consent to the performing of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or the patient named below, for whom I am legally responsible).

I understand that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to sprains, disc injuries, strokes, dislocations, and general aggravations of inflammatory conditions. I understand that I will have the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and procedures. I understand that the doctor will perform an exam in order to minimize any risk of care; however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon facts known, and is in my best interest. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, ____ have read and fully understand the above statements.
(Print name)

__________ (initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company. I also authorize the provider to release any information required to process my claim. I therefore accept chiropractic care on this basis.

__________ (initial) I understand that there is a **24 Hour Cancellation Policy**. I understand I will be charged a $25 no show/cancellation fee at my next scheduled visit, if I fail to cancel within a 24 hour period by calling 831-761-2212.

__________ (initial) I have read the Notice of Privacy Practices document and I agree to its terms.

_______________________________________ (Signature)

___________________________________ (Date)