Welcome to Our Office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About this Patient

First Name	Last Name	Birthday
-	-	-

Cell Phone	Email	Gender
-	-	-

Marital Status	Social Security #	Referred By
-	-	-

Street Address
-

City	State/Province	Zip Code
-	-	-

About the Spouse

First Name	Last Name	Spouse's Cell Phone
-	-	-

Employer Information

Employer
-

Work Address
-

Work City	Work State	Work Zip
-	-	-

Work Phone	Type of Work
-	-

Reason for this Visit

Is the purpose of this appointment related to:
-

If job related, have you made a report of your accident to your employer?
-

Please explain.
-

When did this condition begin?
-

Has this condition
-

Has this condition occurred before?
-

Does this condition interfere with
-

Explain
-

Have you seen other doctors for this condition?
-

Doctor's Name (s)
-

Type of Treatment
-

Results
-

Initial Consultation Form

Primary Complaint (s):
-

Overall frequency of complaint (choose one)
-

Overall intensity of complaint (choose one)
-

Is this problem affecting any other area of your body? If yes, please explain:
-

Does it interfere with your normal daily activities (Family, recreation, sports)?
-

Does your symptoms increase while performing your normal work duties?
-

If yes, please select the amount below that you feel your symptoms increase at work:
-

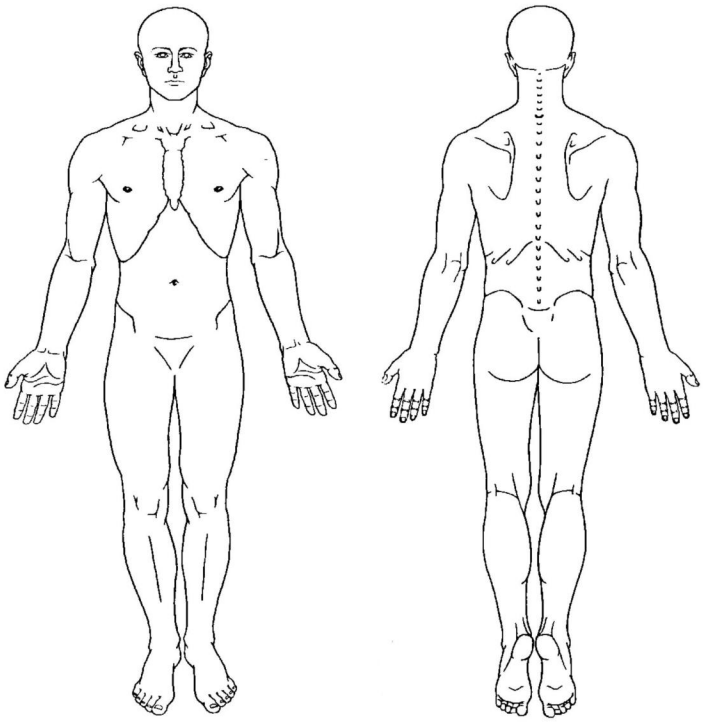
What aggravates the problem?
-

What relieves the problem?
-

If this problem went without being taken care of, how do you think it would affect you?
-

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Experience with Chiropractic

Have you been adjusted by a chiropractor before?
-

Has any adult in your family seen a Chiropractor?
-

Has any child in your family seen a Chiropractor?
-

Doctor's Name
-

Approximate date of last visit?
-

Reason for those visits?
-

Awareness of Chiropractic Principles

Were you aware that...

Doctors of Chiropractic work with the nervous system?
-

The nervous system controls all bodily functions and systems?
-

Chiropractic is the largest natural healing profession in the world?
-

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?
-

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort
-

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms
-

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
-

Health Habits & Conditions

Medications I Now Take:
-

Do you smoke?
-

Do you drink alcohol?
-

Do you drink coffee?
-

Do you exercise regularly?
-

Do you wear:
-

Health Conditions:
-

Nutrition and self-care are just two of the components in obtaining optimal wellness.

Please let us know what you are currently doing for your health.

Things I do currently to support my health include:
-

Please indicate which of these you do/have on a consistent basis:
-

Please list any vitamin supplements you are currently taking
-

For Women Only

Are you pregnant?
-

Are you nursing?
-

Are you taking birth control?
-

Do you experience painful periods?
-

Do you have irregular cycles?
-

Do you have breast implants?
-

Emergency Contact

First Name
-

Last Name
-

Relationship
-

Work Phone
-

Home Phone
-

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-rays is for the examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Who should receive bills for payment on your account?

-

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Signature

Date Signed

-

Printed Name

-

Email

-

Today's payment will be made by:

-

Authorization for Care:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Signature	**Date Signed** -
Printed Name -	**Email** -