





Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Will you be healthier 5 years from now than you are today?                      Y            N            Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? \_\_\_\_\_

After making these changes in your life, how do you expect your health to be 5 years from now?  
 \_\_\_\_\_

Have you had previous chiropractic care?   Y        N

If yes, what was the doctor's name? \_\_\_\_\_

What was the approximate date of your last visit? \_\_\_\_\_

What was the duration of your care? \_\_\_\_\_

Were you aware that:

- Doctors of Chiropractic work with the nervous system?                      \_\_\_Yes    \_\_\_No
- The nervous system controls all bodily functions and systems?                      \_\_\_Yes    \_\_\_No
- Chiropractic is the largest natural healing profession in this world?                      \_\_\_Yes    \_\_\_No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?                      \_\_\_Yes    \_\_\_No

What other wellness professionals are currently parts of your health care team?

- Massage Therapist     Acupuncturist     Naturopath     Homeopath
- Other: \_\_\_\_\_

How many Medical Doctor's office visits did you and your family have last year?

- None     Less than 5     More than 5     More than 10

Is your current condition the result of a **recent**:     auto accident?     work related injury

What was the date of injury? \_\_\_\_\_

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:**

**Primary Complaint** (List one only): \_\_\_\_\_

When did you first experience this problem? \_\_\_\_\_

How did this problem first begin? \_\_\_\_\_

How often do you experience this problem? (Please Circle One)

<25% (Intermittent)    26-50% (Occasional)    51-75% (Frequent)    >76% (Constant)

Please grade the severity of this problem (with 10 being worst):

Now                    1   2   3   4   5   6   7   8   9   10

On Average            1   2   3   4   5   6   7   8   9   10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

\_\_\_\_\_ Burning            \_\_\_\_\_ Stabbing            \_\_\_\_\_ Aching            \_\_\_\_\_ Sharp  
 \_\_\_\_\_ Tingling            \_\_\_\_\_ Numb            \_\_\_\_\_ Other: \_\_\_\_\_

Please describe the location of the pain. \_\_\_\_\_

Does this problem cause pain to travel to any other area?    Y    N    If yes, where? \_\_\_\_\_

Is this problem:            In the AM: ( ) worse?    ( ) better?

   In the PM: ( ) worse?    ( ) better?

What seems to aggravate this problem? \_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? \_\_\_\_\_

Have you seen any other doctors for this problem?    Y    N    If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Secondary Complaint -- if any** (List one only): \_\_\_\_\_

When did you first experience this problem? \_\_\_\_\_

How did this problem first begin? \_\_\_\_\_  
 \_\_\_\_\_

How often do you experience this problem? (Please Circle One)

<25% (Intermittent)    26-50% (Occasional)    51-75% (Frequent)    >76% (Constant)

Please grade the severity of this problem (with 10 being worst):

Now                    1   2   3   4   5   6   7   8   9   10

On Average            1   2   3   4   5   6   7   8   9   10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

\_\_\_\_\_ Burning            \_\_\_\_\_ Stabbing            \_\_\_\_\_ Aching            \_\_\_\_\_ Sharp  
 \_\_\_\_\_ Tingling            \_\_\_\_\_ Numb            \_\_\_\_\_ Other: \_\_\_\_\_

Please describe the location of the pain. \_\_\_\_\_  
 \_\_\_\_\_

Does this problem cause pain to travel to any other area?    Y    N    If yes, where? \_\_\_\_\_  
 \_\_\_\_\_

Is this problem:            In the AM: ( ) worse?    ( ) better?  
                                   In the PM: ( ) worse?    ( ) better?

What seems to aggravate this problem? \_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? \_\_\_\_\_  
 \_\_\_\_\_

Have you seen any other doctors for this problem?    Y    N    If yes, who? \_\_\_\_\_  
 \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### Lifestyle/Social History

Job Description: \_\_\_\_\_

Work Schedule: \_\_\_\_\_

Recreational Activities: \_\_\_\_\_

Do you smoke?	Y	N	If yes, how much?	_____
Do you drink alcohol?	Y	N	If yes, how much?	_____
Do you drink coffee?	Y	N	If yes, how much?	_____
Do you drink tea?	Y	N	If yes, how much?	_____
Do you drink water?	Y	N	If yes, how much?	_____

How regularly do you exercise?     daily     \_\_\_x/week     occasionally     never

What kind of exercise do you do? \_\_\_\_\_

How many hours of sleep do you get on average? \_\_\_\_\_

What position do you regularly sleep in?    Back                      Side                      Stomach

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational	_____
Personal	_____

### Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

When was your last period? \_\_\_\_\_

Are you pregnant?     Yes     No     Not sure

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Please list the cause of death and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries:

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous injuries or trauma (please give type and date): \_\_\_\_\_  
 \_\_\_\_\_

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

Nutritional Supplements you are currently taking:

Supplement & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

Allergies: \_\_\_\_\_  
 \_\_\_\_\_

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

### Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional)	_____	

### Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional)	_____	

## **Please check any of the following you have had in the last 12 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:**

### MUSCULO-SKELETAL

Low Back Pain     
  Pain Between Shoulders     
  Neck Pain     
  Arm Pain  
 Joint Pain/Stiffness     
  Walking Problems     
  Difficult Chewing/Clicking Jaw  
 General Stiffness

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**GENITO-URINARY**

\_\_\_ Painful/Excessive Urination      \_\_\_ Discolored Urine      \_\_\_ Bladder Trouble

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**CARDIO-VASCULAR- RESPIRATORY**

\_\_\_ Chest Pain      \_\_\_ Short Breath      \_\_\_ Blood Pressure Problems  
 \_\_\_ Irregular Heartbeat      \_\_\_ Heart Problems      \_\_\_ Lung Problems/Congestion  
 \_\_\_ Varicose Veins      \_\_\_ Ankle Swelling      \_\_\_ Stroke

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

**NERVOUS SYSTEM**

\_\_\_ Nervous      \_\_\_ Numbness      \_\_\_ Paralysis      \_\_\_ Dizziness  
 \_\_\_ Forgetfulness      \_\_\_ Confusion/Depression      \_\_\_ Fainting      \_\_\_ Convulsions  
 \_\_\_ Cold/Tingling Extremities      \_\_\_ Stress      \_\_\_ Hearing Difficulty

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

**EYES, EARS, NOSE, THROAT**

\_\_\_ Vision Problems      \_\_\_ Dental Problems      \_\_\_ Sore Throat  
 \_\_\_ Ear Aches      \_\_\_ Stuffed Nose

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**GENERAL**

Fatigue  Allergies  Headaches  Fever

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**MALE / FEMALE**

Menstrual Irregularity  Menstrual Cramps  Vaginal Pain/Infection  
 Breast Pain/Lumps  Prostate/Sexual Dysfunction  Other: \_\_\_\_\_

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**GASTRO-INTESTINAL**

Poor/Excessive Appetite  Excessive Thirst  Frequent Nausea  
 Vomiting  Diarrhea  Constipation  
 Hemorrhoids  Liver Problems  Gall Bladder Problems  
 Weight Trouble  Abdominal Cramps  Gas/Bloating after Meals  
 Heartburn  Black/Bloody Stools  Colitis

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please check any of the following illnesses you have ever had:**

Cancer  Diabetes  Mental Disorders  Pneumonia  
 Heart Disease  Rheumatic Fever  Small Pox  Pleurisy  
 Polio  Chicken Pox  Arthritis  Tuberculosis  
 Epilepsy  Whooping Cough  Anemia  Mumps  
 Measles  Thyroid Disorder

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Which best describes your reason for consulting our office?

\_\_\_\_\_ I have a specific concern and require help with this concern.

\_\_\_\_\_ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

\_\_\_\_\_ I want to be healthier five years from now than I am today.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Discover Chiropractic Clinic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditional upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, of there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Discover Chiropractic Clinic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient \_\_\_\_\_

Signature of Patient or Personal Representative \_\_\_\_\_

Date of Signing \_\_\_\_\_



## TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

### **Adjustment**

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

### **Health**

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

### **Vertebral Subluxation**

A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements. *(Print Name)*

### **Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_ being the parent of legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



## Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## E-Practice Form

In our never-ending quest to serve our practice members better, we are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring at Discover Chiropractic (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our tradition of exceeding all your expectations.

Name: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_