Initial Consultation Form

Patient Name: _____ **Primary Complaint:** _____

Describe your condition at its worst: _____

_____

Please circle the appropriate response:

Overall frequency of complaint (circle one)

Constant- 100% of the time **Frequent-** 75% **Intermittent-** 50% **Occasional-** 25%

Overall intensity of complaint (circle one):

- **Minimal** (an annoyance but has no effect on activity)
- **Slight** (tolerable with some impairment of activity)
- **Moderate** (tolerable and cannot perform any activity)
- **Severe** (intolerable and cannot perform any activity)

Is your problem affecting other areas of your body? If yes, please explain: _____

_____

Does it interfere with your normal daily activity (work, family, recreation)? If yes, please explain: _____

_____

What aggravates the problem? _____

What relieves the problem? What have you tried for relief? _____

_____

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

_____

History of past surgeries (approximate dates): _____

_____

Any questions or concerns? _____

Patient's Signature _____ **Date:** _____

PATIENT INFORMATION

Name: _____
Mailing Address: _____
City _____ State ____ Zip _____
Home _____ Cell _____ Work _____
Employer _____
Email Address _____
Birthdate _____
Gender ◯ M ◯ F

SPOUSE OR GUARDIAN INFO

Name _____ DOB: _____

CHIROPRACTIC EXPERIENCE

Who referred you to this office? _____
Have you been adjusted before? ☐ Yes ☐ No
Reason for those visits _____
Physician's Name _____
Approximate date of last visit _____
Has any adult in your family seen a chiropractor? ☐ Yes ☐ No
Has any child? ☐ Yes ☐ No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- Chiropractic physicians work with the nervous system? ☐ Yes ☐ No
- The nervous system controls all bodily functions and systems? ☐ Yes ☐ No
- Chiropractic is the largest natural healing professional in the world? ☐ Yes ☐ No
- If chiropractic care starts at birth, can you achieve a higher level of health throughout life? ☐ Yes ☐ No

REASON FOR THIS VISIT

Describe the purpose of this visit _____
Is the purpose of this appointment related to
☐ Job ☐ Sports ☐ Auto ☐ Fall ☐ Chronic Pain
☐ Home Injury ☐ Other
Please explain _____
If Job related, have you filled out a report of injury through your employer? ☐ Yes ☐ No
When did this condition begin? _____
Has this condition ☐ gotten worse or ☐ stayed constant. Does the pain come and go? ☐ Yes ☐ No
Does this condition interfere with
☐ Work ☐ Sleep ☐ Daily Routine
Other ☐
Has this condition occurred before?
☐ Yes ☐ No
Explain _____
Have you seen other providers for this condition? ☐ Yes ☐ No
Physician Name(s) _____
Type of Treatment _____
Results _____

GOALS FOR MY CARE

People see chiropractors for a variety of reasons. Some go for pain relief, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their bodies. Your physician 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.
☐ Please select the type of care needed

CURRENT MEDICATIONS

- ☐ Nerve
- ☐ Narcotics or NSAIDS
- ☐ Muscle Relaxers
- ☐ Blood Pressure
- ☐ Insulin
- ☐ Stimulants
- ☐ Blood Thinners
- ☐ Tranquilizers

Social History

Do you smoke? ☐ Yes ☐ No

_____Packs/day

Do you drink alcohol? ☐ Yes ☐ No

_____drinks/day

Do you drink coffee? ☐ Yes ☐ No

Do you exercise regularly? ☐ No ☐ Daily ☐ Moderately

Do you wear ☐ Heel Lifts ☐ Sole Lifts

☐ Inner Soles ☐ Arch Support

For Women

Are you taking birth control?

☐ Yes ☐ No

Do you have irregular cycles?

☐ Yes ☐ No

Do you have breast implants?

☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Signature_____ Date:_____

Health History

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ☐ Severe or frequent headaches
- ☐ Sinus Problems
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Pain between shoulders
- ☐ Frequent neck pain
- ☐ Arm/leg/hand numbness
- ☐ Low Back Problems
- ☐ Digestive Problems
- ☐ Ulcers/Colitis
- ☐ Thyroid Problems
- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Disease
- ☐ Heart Surgery/Pacemaker
- ☐ Heart Murmur
- ☐ High/Low Blood Pressure
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcohol/Drug Abuse
- ☐ STD
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Psychiatric Problems

Signature:_____ Date:_____

AUTHORIZATION FOR CARE

I hereby authorize the physician 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 services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The physician will not be held responsible for any pre-existing medically diagnosed conditions or diagnosis(s). I also understand that if I suspend or terminate my care any fees for professional services rendered will become immediately due. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature Date Spouse or Authorized Caregiver Date

Who should receive bills for payment on your account?

◯ Patient ◯ Spouse ◯ Parent ☐ Worker's Comp ◯ Auto Insurance ◯ Medicare

◯ Medicaid ◯ Personal Health Insurance

OWNERSHIP OF XRAY FILMS

It is understood and agreed that the payments to the doctor for X-rays is for 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.

IN AN EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____