Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness		REASON FOR VISIT
Is your condition getting worse?   Yes   No   Constant   Comes and goes.   Is your condition interfering with your:   Work   Sleep or   Daily routine? If so, how:	ve	Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness Are you in pain: Yes No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense Did your injury occur during: Work Sports/play Auto Accident Routine/Household activity When did your condition/accident occur?/_/ Where did your injury occur?
Using the adjacent body charts, please circle all affected areas.  Have you been treated by a Medical Physician for this condition? Dives Mo If so, where?  Have you ever been treated by a Chiropractor? Dives No Clinic or Dr's name:  Clinic or Dr's name:  Clinic phone#:  Blood Thinners Di Tranquilizers I insulin Dother(s)  Blood Thinners Di Tranquilizers I insulin Dother(s)  Blood Thinners Di Tranquilizers I insulin Dother(s)  Wheart Attack / Stroke  YN Heart Sury-Pacemaker YN Heart Murmur  YN Heart Murlous YN No Concor  YN Heart Murlous YN No Concor  YN Heart Sury-Pacemaker YN Heart Murmur  YN Hight Law Book Pack Stroke  YN Concor  YN Heart Sury-Pacemaker YN Heart Murmur  YN Hight Law Book Pack Stroke  YN Concor  YN Heart Sury-Pacemaker YN Heart Murmur  YN Hight Law Book Pack Stroke  YN Concor  YN Heart Sury-Pacemaker YN Heart Murmur  YN Hight Law Book Pack Stroke  YN Concor  YN Heart Bury-Pacemaker YN Heart Murmur  YN Hight Law Book Pack Stroke  YN Concor  YN Heart Sury-Pacemaker YN Heart Murmur  YN Hight Law Book Pack Stroke  YN Concor  YN Heart Sury-Pacemaker YN Heart Bury-Pacemaker YN Heart Bury-Pacemaker YN Hight Law Book Pack Stroke  YN Shingles  YN Emphyseama / Asthma  YN Tuberculosis  YN Emphyseama		Is your condition getting worse?  Yes  No  Constant  Comes and goes.
Are you taking any of the following medications?   Neve pills   Pain killers(including aspirin)   Muscle relaxers		
Have you ever been treated by a Chiropractor?		all affected areas. Have you been treated by a Medical Physician for this condition?   Yes   No If so, where?
### Are you taking any of the following medications?   Nerve pills   Pain killers(including aspirin)   Muscle relaxers   Blood Thinners   Tranquilizers   Insulin   Other(s)		Have you ever been treated by a Chiropractor?   Clinic or Dr's name:  Clinic phone#:
Are you taking any of the following medications?	6	riight Front Back Left
Are you taking any of the following medications?		
Please list anything that you may be allergic to:  Family Health History:  Do you take Supplements or Vitamins?  Yes  No  Do you exercise?  No  Yes  hours per week  Do you smoke?  No  Yes How much?  How long?  No  Yes Since:  / /  Are you wearing:  Shoe lifts  Inner soles  Arch supports  Are you dieting:  No  Yes Since:  / /  For woman:  Are you taking Birth Control?  Yes  No  Are you Nursing?  Yes  No  Are you Pregnant?  No  Yes  If so, how many weeks?  We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge		
Please list anything that you may be allergic to:  Family Health History:  Do you take Supplements or Vitamins?  Yes  No  Do you exercise?  No  Yes  hours per week  Do you smoke?  No  Yes How much?  How long?  No  Yes Since:  / /  Are you wearing:  Shoe lifts  Inner soles  Arch supports  Are you dieting:  No  Yes Since:  / /  For woman:  Are you taking Birth Control?  Yes  No  Are you Nursing?  Yes  No  Are you Pregnant?  No  Yes  If so, how many weeks?  We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	YN High/L YN Ulcers YN Difficu	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC es Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes W Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever Y N Severe / Frequent Headaches Y N Kidney Problems Y N Fainting/Seizures/Epilepsy Y N Sinus Problems Y N Emphysema / Asthma Y N Tuberculosis Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis
Do you take Supplements or Vitamins?  Yes No Do you exercise?  No Yes hours per week Do you smoke?  No Yes How much?  How long?  No Yes Since: / / Are you wearing:  Shoe lifts Inner soles Arch supports Are you dieting:  No Yes Since: / / For woman: Are you taking Birth Control?  Yes No Are you Pregnant?  No Yes If so, how many weeks?   We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes W Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever Y N Severe / Frequent Headaches Y N Kidney Problems Y N Severe / Frequent Headaches Y N Kidney Problems Y N Emphysema / Asthma Y N Tuberculosis Y N Lower Back Problems Y N Arthritis St any surgeries with dates and/or any other serious medical condition(s) not listed above:
Do you smoke? No Yes How much? How long?  Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: / /  For woman: Are you taking Birth Control? Yes No  Are you Nursing? Yes No Are you Pregnant? No Yes If so, how many weeks?  We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes Y N Severe / Frequent Headaches Y N Kidney Problems Y N Sinus Problems Y N Sinus Problems Y N Sinus Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:  past serious accidents with dates:  st anything that you may be allergic to:
Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: // For woman: Are you taking Birth Control? Yes No Are you Nursing? Yes No Are you Pregnant? No Yes If so, how many weeks?  We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Glaucoma Y N Anemia / Diabetes Y N Severe / Frequent Headaches Y N Kidney Problems Y N Fainting/Seizures/Epilepsy Y N Sinus Problems Y N Sinus Problems Y N Emphysema / Asthma Y N Tuberculosis Ity Breathing Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:  past serious accidents with dates:  st anything that you may be allergic to:  lealth History:
<ul> <li>We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.</li> <li>Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.</li> <li>I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.</li> <li>I understand the above information and guarantee this form was completed correctly to the best of my knowledge</li> </ul>	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes Y N Severe / Frequent Headaches Y N Kidney Problems Y N Sinus Problems Y N Sinus Problems Y N Emphysema / Asthma Y N Tuberculosis Ity Breathing Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:
friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H Do you t Do you s Are you	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes by Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever Y N Severe / Frequent Headaches Y N Kidney Problems Y N Emphysema / Asthma Y N Tuberculosis Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:  past serious accidents with dates:  st anything that you may be allergic to:  lealth History:  ake Supplements or Vitamins? Yes No Do you exercise? No Yes hours per week smoke? No Yes How much?  How long?  wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since:  / N HIV+ / AIDS / ARC Y N HIV+ / AIDS / ARC Y N Glaucoma Y N Anemia / Diabetes Y N Severe / Frequent Headaches Y N Kidney Problems Y N Tuberculosis Y N Colitis Y N Chemotherapy Y N Chemotherapy Y N Arthritis  Y N HIV+ / AIDS / ARC Y N Glaucoma Y N Anemia / Diabetes Y N Severe / Frequent Headaches Y N Kidney Problems Y N Tuberculosis Y N Chemotherapy Y N Chemotherapy Y N Arthritis  St any surgeries with dates and/or any other serious medical condition(s) not listed above:  past serious accidents with dates:  by N Chemotherapy Y N Chemotherapy
friendly, mutual understanding between provider and patient.  Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H Do you t Do you s Are you	al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes by Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever Y N Severe / Frequent Headaches Y N Kidney Problems Y N Emphysema / Asthma Y N Tuberculosis Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:
made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H Do you t Do you s Are you For won	al Valves
■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  ■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H Do you t Do you s Are you Are you	Al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N Hepatitis Y N Alcohol / Drug Abuse Y N Prequent Neck Pain Y N Gancer Y N Prequent Neck Pain Y N Galucoma Y N Alcohol / Problems Y N Remarks Fever Y N Fainting/Seizures/Epilepsy Y N Sinus Problems Y N Severe / Frequent Headaches Y N Kidney Problems Y N Emphysema / Asthma Y N Tuberculosis Ity Breathing Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:  past serious accidents with dates:  st anything that you may be allergic to:  lealth History:  ake Supplements or Vitamins? Yes No Do you exercise? No Yes hours per week smoke? No Yes How much?  How long?  wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since:    Y N Hepatitis Y N Hepatitis Y N Althritis Y N Alleria / Y N Alemia / Diabetes Y N Kidney Problems Y N Severe / Frequent Headaches Y N Kidney Problems Y N Emphysema / Asthma Y N Arthritis Ity Ity Emphy
■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H Do you t Do you s Are you For won Are you  We inv friendly Our po made arrange	Al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitits Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes by Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever Y N Severe / Frequent Headaches Y N Kidney Problems Y N Sinus Problems Y N Sinus Problems Y N Emphysema / Asthma Y N Tuberculosis Ity Breathing Y N Chemotherapy Y N Lower Back Problems Y N Artificial Bones/Joints/Implants Y N Arthritis st any surgeries with dates and/or any other serious medical condition(s) not listed above:  past serious accidents with dates:  st anything that you may be allergic to:  lealth History:  ake Supplements or Vitamins? Yes No Do you exercise? No Yes hours per week moke? No Yes How much?  How long?  wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since:  nan: Are you taking Birth Control? Yes No No Yes If so, how many weeks?  ite you to discuss with us any questions regarding our services. The best health services are based on a mutual understanding between provider and patient.  licy requires payment in full for all services rendered at the time of visit, unless other arrangements have been with the business manager. If account is not paid within 90 days of the date of service and no financial ements have been made, you will be responsible for legal fees, collection agency fees, interest charges and
	Y N High/L Y N Ulcers Y N Difficu Please li List any Please li Family H Do you t Do you s Are you  We inv friendly Our po made arrang any oth I autho	Al Valves Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis Y N HIV+ / AIDS / ARC Y N Cancer Y N Frequent Neck Pain Y N Glaucoma Y N Anemia / Diabetes Y N Glaucoma Y N Frequent Py N Frequent Py N Glaucoma Y N Ridney Problems Y N Ridney Problems Y N Severe / Frequent Headaches Y N Kidney Problems Y N Frequent Headaches Y N Frequent

□ Spouse

☐ Parent or Guardian

Signature

Initials

Comments