

3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day? < 1 1-3 3-5 >5

Do you usually snack while watching television? yes no

How many hours per day do you use a computer at work or home? < 1 1-3 3-5 >5

How many hours per day do you ride in a car or other vehicle? < 1 1-3 3-5 >5

How often do you exercise? daily 3x's/week 2x's/week 1x/week I don't exercise

How long do your exercise work outs last? >1 hour 1 hour 30 minutes < 30 minutes NA

What are your exercise activities? (mark all that apply) I don't exercise

walking swimming weight lifting

stretching/flexibility yoga/Pilates resistance bands

running/treadmill/rowing/climbing group exercise classes other _____

Do you take a multi-vitamin? yes no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tobacco? never daily weekly monthly yearly

How many servings of alcohol do you drink each week? 0 1-2 3-5 >5

How many servings of coffee do you drink each week? 0 1-2 3-5 >5

How many servings of soda do you drink each week? 0 1-2 3-5 >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
heart problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
kidney problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
cancer	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
headaches	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
back pain	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
obesity	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
poor conditioning	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	low back pain	<input type="checkbox"/> yes <input type="checkbox"/> no	polio	<input type="checkbox"/> yes <input type="checkbox"/> no
anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	goiter	<input type="checkbox"/> yes <input type="checkbox"/> no	measles	<input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	mental disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV positive	<input type="checkbox"/> yes <input type="checkbox"/> no	mumps	<input type="checkbox"/> yes <input type="checkbox"/> no	venereal infection	<input type="checkbox"/> yes <input type="checkbox"/> no
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	influenza	<input type="checkbox"/> yes <input type="checkbox"/> no	pleurisy	<input type="checkbox"/> yes <input type="checkbox"/> no	whiplash	<input type="checkbox"/> yes <input type="checkbox"/> no
				pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough	<input type="checkbox"/> yes <input type="checkbox"/> no

Mark the following conditions that are **currently** a cause of significant concern for you.

General

- | | | | | |
|--|------------------------------------|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> consistent fainting | <input type="checkbox"/> chills | <input type="checkbox"/> convulsions | <input type="checkbox"/> depression | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> loss of weight | <input type="checkbox"/> fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> headache | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> neuralgia | <input type="checkbox"/> night sweats | <input type="checkbox"/> wheezing | <input type="checkbox"/> nervousness |

Gastro-Intestinal

- | | | | | |
|--|-----------------------------------|--|--|---|
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> gall bladder problems | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> liver problems | <input type="checkbox"/> nausea | <input type="checkbox"/> stomach pain | <input type="checkbox"/> poor appetite | <input type="checkbox"/> poor digestion |
| <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | <input type="checkbox"/> vomiting blood | | |

Eye/Ear/Nose/Throat

- | | | | | |
|--|---|---|--------------------------------------|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> crossed eyes | <input type="checkbox"/> deafness | <input type="checkbox"/> earache | <input type="checkbox"/> ear discharge |
| <input type="checkbox"/> ear noises | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> frequent colds | <input type="checkbox"/> hay fever | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> nasal obstruction | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> pain in eyes | <input type="checkbox"/> poor vision | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> tonsillitis | | | |

Respiratory

- | | | | | |
|-------------------------------------|--|---|---|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chronic cough | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> spitting blood | <input type="checkbox"/> spitting phlegm |
|-------------------------------------|--|---|---|--|

Muscles/Joints/Bones

- | | | | | |
|---|---|--|---|-------------------------------------|
| <input type="checkbox"/> backache | <input type="checkbox"/> foot problems | <input type="checkbox"/> pain bet. shoulders | <input type="checkbox"/> painful tailbone | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> spinal curvature | <input type="checkbox"/> swollen joints | <input type="checkbox"/> tremors | <input type="checkbox"/> twitching | <input type="checkbox"/> weakness |

Cardio-Vascular

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> heart trouble | <input type="checkbox"/> pain over heart |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> rapid heart | <input type="checkbox"/> slow heart | <input type="checkbox"/> strokes | |

Skin or Allergies

- | | | | | |
|---|----------------------------------|---------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> dryness | <input type="checkbox"/> eczema | <input type="checkbox"/> hives | <input type="checkbox"/> itching |
| <input type="checkbox"/> sensitive skin | | | | |

Women

- | | | | | |
|---------------------------------|---|--------------------------------------|--|--|
| <input type="checkbox"/> cramps | <input type="checkbox"/> excessive flow | <input type="checkbox"/> hot flashes | <input type="checkbox"/> irregular cycle | <input type="checkbox"/> painful periods |
|---------------------------------|---|--------------------------------------|--|--|

WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? yes no On what date did your last period begin?

Do you want to take a pregnancy test now? yes no

OFFICE USE ONLY
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

- | | | | | | |
|---|--|----------------------------------|--|-------------------------|--|
| tubal ligation | <input type="checkbox"/> yes <input type="checkbox"/> no | complete or partial hysterectomy | <input type="checkbox"/> yes <input type="checkbox"/> no | partner had a vasectomy | <input type="checkbox"/> yes <input type="checkbox"/> no |
| less than 10 days since the start of my last period | <input type="checkbox"/> yes <input type="checkbox"/> no | taking birth control pills | <input type="checkbox"/> yes <input type="checkbox"/> no | | |

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date

1 BENEFITS ASSIGNMENT

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

patient or guardian signature _____

date _____

2 INFORMATION RELEASE

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

patient or guardian signature _____

date _____

INSURANCE VERIFICATION

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a **Workers' Comp** case? yes no

Has the injury been reported? yes no

Name: _____

Title: _____

Is patient currently employed at place of injury? yes no

Name of person authorizing care: _____

Is this an **Auto Collision** or **Personal Injury** case? yes no

Has it been reported to the insurance company? yes no

Has an application for benefits been filed? yes no

Did the police write a report? yes no

Is auto or PI insurance primary? yes no

Agent name and contact info: _____

Does the plan cover the following services?

chiropractic adjustments yes no

modalities:

hot/cold packs yes no

mechanical traction yes no

electric stimulation yes no

ultrasound yes no

therapeutic exercise and activities yes no

neuromuscular re-education yes no

massage yes no

manual therapy technique yes no

exams yes no

supports, braces, collars yes no

pillows yes no

nutritional supplements yes no

orthotics yes no

other: _____ yes no

other: _____ yes no

Does the plan have a deductible? yes no

Amount for an individual: _____

Amount for the family: _____

Amount currently met: _____

When does the deductible renew? _____

Do charges for diagnostic tests apply to the deductible? yes no

What is the co-pay after the deductible is met? _____

What is the maximum yearly benefit? _____

What is the yearly visit cap? _____

Does the company assign benefits to the doctor? yes no

Are any special forms required to file claims? yes no

What is the name of the person that you spoke with?

Last: _____

First: _____

ID# _____

Extension: _____

Notes: _____