Name_____ Date of Birth_____/_____/_____ Male/Female

Address_____City_____State_____Zip_____

Phone: Cell _____ Home_____ Business_____

Email Address_____ Occupation_____

Single / Married / Divorced / Widowed / Partnered Spouse's Name_____

Number of Children_____ Names & Ages _____

Who may we thank for referring you to our office? _____

Previous Chiropractic Care? YES / NO Approximate Last Visit Date _____

FAMILY HISTORY:

HEALTH HISTORY (PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)

Heart Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Stroke Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Cancer Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Type of Cancer: _____

Any other family history that might be relevant: _____

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Surgeries – Date, Type and Reason: _____

_____

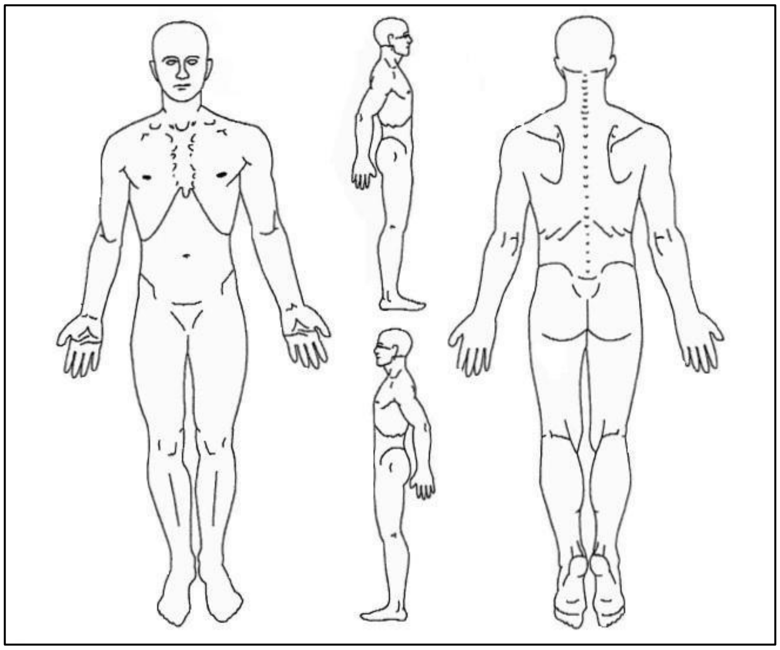
_____

Major Injuries / Traumas: (List even if it was 20 years ago…) _____

_____

Subjective Questionnaire

Name: ____



Circle each area of pain.
Use one box per area below to describe pain.
Please make sure to fill out each box completely.

Area of pain:

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Constant Off/On Episodes per week/month
Radiate: N / Y Where ?:
Better: Ice Heat Rest Movement Stretching Medication
Worse: Sit Stand Walk Lying Sleep Bending Working Overuse All

Pain Level **Now**: 0 1 2 3 4 5 6 7 8 9 10
Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10
Typical/Average Pain: 0 1 2 3 4 5 6 7 8 9 10
Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

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Name: _____

Are you *currently* experiencing any of these symptoms? *(Check all that apply)*

Many of the following conditions respond to Chiropractic treatment.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _____
- ❑ Leg Problems _____
- ❑ Painful Joints _____
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones _____
- ❑ Other: _____
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or tingling sensations
- ❑ Loss of Feeling
- ❑ Dizziness or light headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ **Ever** been in an auto accident?
- ❑ Date of last accident? _____
- ❑ Other: _____
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Frequent Urination
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ *None in this Category*

Signature: _____

Date: _____

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Blurred or double vision
- ❑ History of Ocular Migraines
- ❑ Eye disease or injury
- ❑ Other: _____
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Swollen throat or voice change
- ❑ Swollen glands in neck
- ❑ Ringing in the ears
- ❑ Ear – Ache / Ringing / Drainage
- ❑ Sinus / Allergy problems
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or urination
- ❑ Cold Extremities
- ❑ Heat or Cold intolerance
- ❑ Change in hat or glove size
- ❑ Dry skin
- ❑ Glandular or hormone problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Immune system disorder
- ❑ Other:
- ❑ None *in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in hair or nails
- ❑ Non-healing sores
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes Due Date: _____
- ❑ No

Last Menstrual Period: _____
- ❑ Infertility
- ❑ Painful or Irregular periods
- ❑ Other: _____
- ❑ *None in this Category*

Number of Children _____

Informed Consent for Chiropractic Care

When a person seeks chiropractic care and that person is accepted for such care, it is essential for the chiropractor and patient/practice member to be working toward the same goal. Chiropractic care has only one objective. It is important that each person involved understand both the objective and the method used to attain it. This will prevent any confusion or disappointment. The following Definitions will help you understand the objective of your Chiropractor. **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 an alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate (natural) ability to express its maximum health potential. **Chiropractic Adjustment:** A Chiropractic adjustment is a method of specific application of forces to the spine to facilitate the body's correction of vertebral subluxation. **We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.** 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 that you seek the services of a health care provider that specializes in that area. **Regardless of what the disease or condition is called, we do not offer to treat it.** Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY OBJECTIVE is to eliminate a major interference to the expression of the body's innate, or inborn, intelligence. Our only method is specific adjusting to correct vertebral subluxation.**

Disclosures

- Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.
- You'll receive a copy of the Notice of Privacy Practices for Protected Health Information in office. This notice is effective as of today's date and will expire seven years after the date upon which the record was created.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. The Source Specific Chiropractic does not accept assignment of insurance benefits.
- If my case is accepted by The Source Specific Chiropractic, chiropractic adjustments will be performed in our adjusting area, where others may be receiving adjustments. I understand and consent to this form of care.
- I consent to receive reminders of appointments, events, newsletters, birthday cards, or welcome cards.
- I consent to have my spouse/significant other present during my report of findings.
- We may mail health articles, newsletters and other information directly to your home or email.
- We may leave a message at your home with someone or on an answering machine.
- Should you share a written testimonial with us, we may display it in binders or use it in our advertising. Our office will receive direct or indirect remuneration from our marketing activities. This notice is effective as of today's date and will expire seven years after the date on which you last received services from us.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

<u>Consent to Evaluate and Adjust a Minor Child:</u>

I, _____ being the parent or legal guardian of_____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

Notice of Privacy Policies: This facility has posted a copy of our Privacy Practices on our website. If you would like a copy, one will be provided at your request. In brief, it states that we will not give any information about you except as consented.

I have reviewed and understand the Privacy Practices of this office.

_____ _____

Signature Date

Third Party Authorization Consent

Please list any individuals you give us permission to discuss your health, finances, appointment times etc.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Emergency Contact Information

If emergency contact is same as above please initial next to their name.

Name: _____ Phone Number: _____

I authorize The Source Specific to discuss my health, finances, and appointments with the people I listed above.

Print Name: _____ Signature: _____ Date: _____

Or

I don't want any of my information discussed with anyone other than myself.

Print Name: _____ Signature: _____ Date: _____