

Welcome to Our Office



Patient File Number _____ **Date:** _____

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (____) _____ - _____ **Work Phone:** (____) _____ - _____

Cell Phone: (____) _____ - _____ **Carrier:** _____ (For Text message Appt reminders)

Email: _____

Social Security Number: _____ - _____ - _____ **Date of Birth:** ____/____/____

Family Data **Marital Status:** Single Married Other

Is your spouse a patient in the clinic? Yes No

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Home Phone: (____) _____ - _____ **Work Phone:** (____) _____ - _____

Date of Birth: ____/____/____ **Social Security Number:** _____

Children's Ages & Names _____

Employer Data **Employment Status:** Employed Student Other

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contact

Contact Name: _____ **Relationship:** _____

Contact Phone: (____) _____ - _____

What is your Wellness Quotient?

Place an "X" that denotes where you believe is your current level of wellness

Place an "O" indicating where you would like your wellness to be.

0 - 50	51 - 70	71 - 80	81 - 90	91 - 100
Very Challenged	Challenged	Transitional	Good	Excellent

Who referred you to our family practice? _____

On a scale of 1-10 (1=poor, 10=excellent) describe your health and condition as it relates to:

Eating _____ Exercise _____ Sleep _____ General Health _____ Wellness Lifestyle _____

Doctor Preference: Dr. King Dr. Amanda



Discover what chiropractic wellness can do for your family

Your Health History



Family Health History: Have you or a relative ever had any of the following conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> Neck Pain (parent/sibling/self) | <input type="checkbox"/> Anemia (parent / sibling / self) | <input type="checkbox"/> Artificial Bones/Joints (parent / sibling/ self) |
| <input type="checkbox"/> Headaches (parent/sibling/self) | <input type="checkbox"/> Thyroid (parent / sibling / self) | <input type="checkbox"/> Emphysema (parent/ sibling /self) |
| <input type="checkbox"/> Low Back Pain (parent / sibling/ self) | <input type="checkbox"/> Psychiatric (parent / sibling / self) | <input type="checkbox"/> Difficulty Breathing (parent/ sibling /self) |
| <input type="checkbox"/> Asthma (parent / sibling / self) | <input type="checkbox"/> Hepatitis (parent / sibling / self) | <input type="checkbox"/> Congenital Heart Disease (parent /sibling/self) |
| <input type="checkbox"/> Cancer (parent / sibling / self) | <input type="checkbox"/> Ulcers/Colitis (parent/ sibling /self) | <input type="checkbox"/> Fainting (parent / sibling / self) |
| <input type="checkbox"/> Seizures (parent/ sibling /self) | <input type="checkbox"/> Glaucoma (parent / sibling / self) | <input type="checkbox"/> Mitral Valve Prolapse (parent/ sibling /self) |
| <input type="checkbox"/> Diabetes (parent /sibling / self) | <input type="checkbox"/> Hypertension (parent/ sibling /self) | <input type="checkbox"/> Shingles (parent/ sibling /self) |
| <input type="checkbox"/> Heart Attack (parent / sibling / self) | <input type="checkbox"/> Heart murmur (parent / sibling / self) | <input type="checkbox"/> Kidney Problems (parent / sibling/ self) |
| <input type="checkbox"/> Arthritis (parent / sibling / self) | <input type="checkbox"/> Sleeping Problems (parent/ sibling /self) | <input type="checkbox"/> Venereal Diseases (parent / sibling/ self) |
| <input type="checkbox"/> Stroke (parent/ sibling /self) | <input type="checkbox"/> Skin Disorder (parent / sibling / self) | <input type="checkbox"/> Chemotherapy Radiation (parent/sibling/self) |
| <input type="checkbox"/> Sinus Problems (parent / sibling / self) | <input type="checkbox"/> Alcohol/Drug Abuse (parent / sibling / self) | <input type="checkbox"/> Autism / PDD (parent / sibling / self) |
| <input type="checkbox"/> High blood pressure (parent / sibling/ self) | <input type="checkbox"/> Cholesterol (parent / sibling / self) | <input type="checkbox"/> ADD/ADHD (parent / sibling / self) |
| <input type="checkbox"/> Heart Surgery/Pacemaker (parent / sibling/ self) | | <input type="checkbox"/> Other _____ |

List Any Surgeries & When Were They Performed: _____

List Any & All Accidents With Dates: _____

Allergies:

Please list anything you may be allergic to: _____

Social History:

- | | |
|--|--|
| <i>Caffeine:</i> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often | <i>Depressed:</i> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often |
| <i>Tobacco:</i> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often | <i>Alcohol:</i> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often |
| <i>Stressed:</i> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often | <i>Wear seat belts:</i> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> always |

List ALL Prescription Drugs: _____

Over the Counter Drugs: _____

List Nutritional Supplements: _____

Tell Us About Your Health Objectives:

What are your health objectives/Chief Complaint? _____

How often do you experience your health challenges?

- Constantly (76-100% of the day) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

What describes the nature of your health challenges?

- Shooting Dull ache Numb Burning Tingling Stabbing Throbbing
- Sharp Radiating pain Stiffness Physical Emotional Chemical

Rate your symptoms today: 0= None

None 0 1 2 3 4 5 6 7 8 9 10 Severe



Are your health problems? Getting better Not changing Getting worse

What aggravates condition? _____ Does anything offer relief? _____

It interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other doctors seen for these health problems (please list)

- Chiropractor _____
- Medical Doctor _____
- Other _____



Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Others _____

Who is your Family Medical Doctor? _____

Who is your Pediatrician? _____

<p>Have you ever:</p> <p>Purchased bottled water: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Belonged to a health club: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Would you like to know more about:</p> <p><input type="checkbox"/> Proper nutrition & diet</p> <p><input type="checkbox"/> Proper exercise routines & techniques</p> <p><input type="checkbox"/> How to deal with lifestyle stresses</p>
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The statements made on this form are accurate to the best of my recollection and I consent to a chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fees for service rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ **Date:** _____

Thank you. Please return to the front desk.



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