

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. Jamey 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? _____

Have you ever:

Purchased bottled water: Yes No

Belonged to a health club: Yes No

Would you like to know more about:

Proper nutrition & diet

Proper exercise routines & techniques

How to deal with lifestyle stresses

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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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____