A Therapeutic Effect

Personal Data

Patient's Name: _____ **Today's Date:** _____

Address: _____ **Phone Number:** _____ (preferred) OK to leave message? **Y or N**

_____ _____ (other) **Y or N**

** Please indicate best number for us to call should we need to cancel an appointment due to weather, illness, or other emergency **

email: _____

How should we confirm your appointments? **Phone Call** or **Automated Email** (please circle one)

Date of Birth: ____ / ____ / ____ (month / day / year) **Sex:** Male ☐ Female ☐ Transgender ☐

Occupation: _____ **Referred by:** _____

Emergency Contact: _____ **Phone Number:** _____ (preferred) OK to leave message? **Y or N**

Relationship: _____ _____ (other) **Y or N**

Are you currently under a Physician's care? Yes No

If yes, please explain: _____

Please list and date any past or present injuries, accidents, or medical treatment including surgeries:

_____

_____

Are you pregnant? Yes No ***If yes, some services may not be administered.***

Please list all known allergies: _____

Please list all medications and supplements you are taking: _____

_____

CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 24 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that "no show" will be charged in full to cover the therapist's time.

Chiropractic New Client Information **Client Name:** _____

What is your main complaint: _____

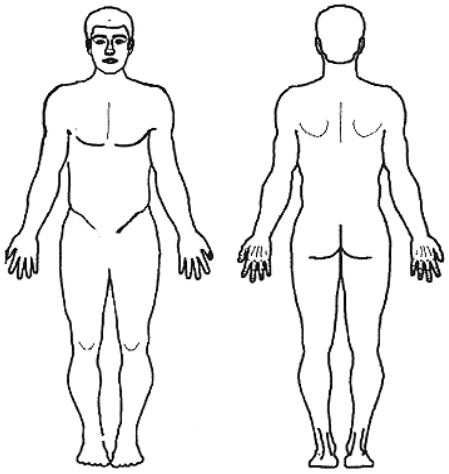
Date symptoms began: _____ **How symptoms began:** _____

Do you have: (please circle) Headaches Neck pain Mid-back pain Low back pain

Other (describe) _____

Is this: Work Related Auto Related N/A

Mark an X on the picture where you have pain or other symptoms



How do you feel today:

1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

- ☐ 0-25% (Intermittent)
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores?

1 2 3 4 5 6 7 8 9 10

No interference Unable to carry on any activities

Have you had spinal x-rays, MRI, CT Scan for your area(s) of complaint? Yes No

If yes, date(s) taken: _____ What areas were taken? neck mid back low back

Please circle all of the following that apply to you:

Recent Fever	Prostate Problems	Diabetes	Prescription birth control
High Blood Pressure	Urinary Problems	Pain at Night	Pain Unrelieved by Position or Rest
Abnormal Weight Gain	Abnormal Weight Loss	Epilepsy/Seizures	Marked Morning Pain/Stiffness
Dizziness/Fainting	Menstrual Problems	Osteoporosis	Numbness in Groin/Buttocks
Visual Disturbances	Stroke (date) _____	Corticosteroid Use (corisone, prednisone, etc.)	
Cancer / Tumor (please explain) _____		Currently Pregnant, # of weeks _____	

Surgeries (explain) _____

Medications _____

Other Health Problems (explain) _____

Family History (please circle) Cancer Diabetes High Blood Pressure Rheumatoid Arthritis Heart Problems/Stroke

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendred and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____