Welcome to High Point Chiropractic

NAME _____ DATE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

PHONE(H) _____PHONE (M) _____PHONE(W)_____ BIRTHDATE_____

WHO REFERRED YOU TO US?_____

OCCUPATION _____ EMPLOYER _____

SPOUSE _____CHILDREN (NAMES/AGES) _____

_____

E-MAIL ADDRESS _____SSN_____

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION _____

_____ LAST VISIT _____

CURRENT MEDICAL TREATMENT? YES/NO WHY? _____

CURRENT DRUGS/MEDICATION _____

PAST SURGERIES: _____

WOMEN: ARE YOU PREGNANT? ____ NURSING? ___ TAKING BIRTH CONTROL PILLS? ____

Other Past Medical Information (Trauma, Serious Illness, hospitalizations, chronic conditions):

_____

_____

_____

_____

Addressing the Issue That Brought You to the Office

If you have no symptoms or complains, and are here for wellness services, please check here ____ "**I wish to have chiropractic Wellness Services**" and skip to "**Family Health Profile**."

If you do have a specific health concern, please briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

_____

If you are experiencing pain, is it…

___ Sharp ___ Dull ___Comes/goes ___Travels ___Constant

Since the problem started, it is… ___ About the same ___Worse ___Better

What makes it worse: _____

Yes, it interferes with: ___Work ___Sleep ___Walking ___Sitting

___Hobbies ___Leisure ___Other: _____

On a Pain Scale of 0-10 (10 being worst), number your pain: _____

Other Doctors seen for this problem (please list):

Chiropractor: _____

Medical Doctor: _____

Other: _____

PLEASE COMPLETE ALL SECTIONS

Please check all the symptoms you have had with any frequency, even if they do not seem related to your current problem:

__ Headaches	__ Pins and needles in legs	__ Fainting	__ Neck Pain
__ Pins and Needles in arms	__ Loss of smell	__Back Pain	__ Loss of Balance
__ Dizziness	__ Buzzing in ears	__ Ringing in ears	__ Nervousness
__ Numbness in fingers	__ Numbness in toes	__ Loss of taste	__ Stomach upset
__ Fatigue	__ Depression	__ Irritability	__ Tension
__ Sleeping problems	__ Neck stiff	__ Cold hands	__ Cold feet
__ Diarrhea	__ Constipation	__ Fever	__ Hot flashes
__ Cold sweats	__ Lights bother eyes	__ Problem urinating	__ Heartburn
__ Mood swings	__ Menstrual pain	__ Menstrual irregularity	__ Ulcers

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

❑ I am only concerned about relief of a particular symptom.

❑ I am only concerned about relief of a particular symptom, and preventing its return.

❑ I want optimum health and wellbeing on every level available to me.

Daily Habits:

What type of exercise do you perform on a daily basis? _____

Do you belong to a health club? _____ Yes _____ No If yes, which one? _____

What vitamins or supplements do you currently take? _____

Do you smoke? _____ Yes _____ No How much per day? _____

How much alcohol do you consume weekly? _____ How many caffeinated beverages per day? _____

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 man have about your:

Children:_____ Spouse: _____

Mother:_____ Father: _____

Brothers:_____ Sisters:_____

Others: _____

To the best of my knowledge, the about information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.
I certify that I, and/or my dependent(s), have insurance coverage with _____ And assign directly to High Point Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
High Point Chiropractic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of patient, guardian or personal representative | date

_____ _____

Please print name of patient, parent, guardian, or personal representative | relationship to patient

PLEASE COMPLETE ALL SECTIONS