Name		**Today's Date:**	
Street Address			
City/State/Zip			
Birth Date		Home Phone #	
Age		Cell Phone #	
Race		Cell Phone Carrier	
Marital Status M – S—W-- D		Email Address:	
How many Children?			
Name & Ages of Children			
Emergency Contact Name & Phone			
Family Medical Doctor Name & Phone			
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?			
How were you referred to our office			

EMPLOYMENT INFORMATION			
Occupation			
Employer		Employer's Phone	
Employer's Address			
Spouse's Occupation			
Spouse's Employer			

PAST MEDICAL HISTORY							
Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)							
Broken or Fractured Bones		Cancer		Excessive Bleeding		Drug Addiction	
Circulatory Problems		Ruptures		High/Low Blood Pressure		HIV Positive	
Rheumatoid Arthritis		Coughing Blood		Osteoarthritis		Gall Bladder	
Seizures/Convulsions		Eating Disorder		Epilepsy		Depression	
A Congenital Disease		Alcoholism		Pace Maker		Ulcers	
Do you have a history of stroke or hypertension?							
Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates)							
Have you been treated for any health condition by a physician in the last year? If yes, describe							
What medications or drugs are you taking?							
Do you have any allergies to any medications? If yes, describe							
Do you have any allergies of any kind? If yes, describe							
Please list any other health problems you have, no matter how insignificant they may be:							

SOCIAL HISTORY					
Do you drink alcoholic beverages?		If so, how much per week?			
Do you use any tobacco products?		If so, how packs per day:			
Do you take vitamin supplements?		If so, please list			
Do you consume caffeine?		If so, how much per day			
Do you exercise?		If yes, what is the frequency and type of exercise?			
What are your hobbies?					
What percentage of time during the day (at home or at your job) do you spend		Working at a computer	Sitting	Bending	Lifting

FAMILY HISTORY					
Parents	Living or Deceased	Age	Cause of death and age at death if deceased		
Father					
Mother					
FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):					
Check if applicable to you. As an adopted child, little is known of birth parents or family.					
Tuberculosis		Cancer		Mental Illness	
Diabetes		Asthma		Heart Disease	
Stroke		Kidney Disease		Lung Disease	
Arthritis		Liver Disease			
Other					

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. If you are sent to collections, you will be charged the cost of collections which is a minimum of $100.00.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature	Date:
Guardian's Signature Authorizing Care:	Date:

HISTORY OF PRESENT ILLNESS	
1.	Chief Complaint: Purpose of this appointment (R___ L___ Both___)
2.	Date symptoms appeared or accident happened. Is this due to: Auto ___ Work___ Other___
3.	Prior neck/back pain? None____ On/Off for years____ Years ago____
4.	Describe the pain? Achy___ Burning___ Dull___ Sharp___ Stiff___ Throbbing___
5.	How frequent is the pain? Constant _____ Daily ____ Intermittent ____ Night Only ___
6.	When does it feel worse? No change___ Morning___ As day progresses___ Afternoon___ Evening___ During the night___
7.	What exacerbates the symptoms? NECK: Resting___ Sleeping___ Walking___ Working___ Movement (any)___ BACK: Driving___ Lifting___ Movement (any)___ Resting___ Sleeping___ Sitting___ Standing___ Walking___ Working___
8.	When does it feel better? No change___ Morning___ As day progresses___ Afternoon___ Evening___ During the night__
9.	What alleviates the symptoms? NECK: Nothing___ Cold___ Warmth___ Medication___ Movement___ Resting___ Sleeping___ Walking___ BACK: Nothing___ Cold___ Warmth___ Medication___ Movement___ Resting___ Sleeping___ Walking___
10.	Which motion do you experience decreased mobility? None___ All___ Flexion___ Extension___ Left Rotation___ Right Rotation___ Left Bending___ Right Bending___
11.	When are you experiencing pain with movement? No Pain___ Flexion___ Extension___ Left Rotation___ Right Rotation___ Left Bending___ Right Bending___