

**ABOUT YOU**

Name: \_\_\_\_\_  
First M.I. Last

DOB: \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_  
Street/PO Box

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ # of Children: \_\_\_\_\_

City, State Zip

Email Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home Cell

Marital Status:  S  M  D  W  Other

Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT \_\_\_\_\_

May we talk to you spouse about your account?  Y  N

May we call you at work?  Y  N

Who referred you to the clinic? \_\_\_\_\_

**FOR MINORS/IF UNDER 18 YEARS OLD ONLY:**

Parent/Guardian Name: \_\_\_\_\_

Have you seen or heard of our clinic because of/from:

Parent/Guardian Address (if different from above): \_\_\_\_\_

Sign  Yellow Pages  Community Event

Street/PO Box City, State Zip

Website  Mailing  Newspaper

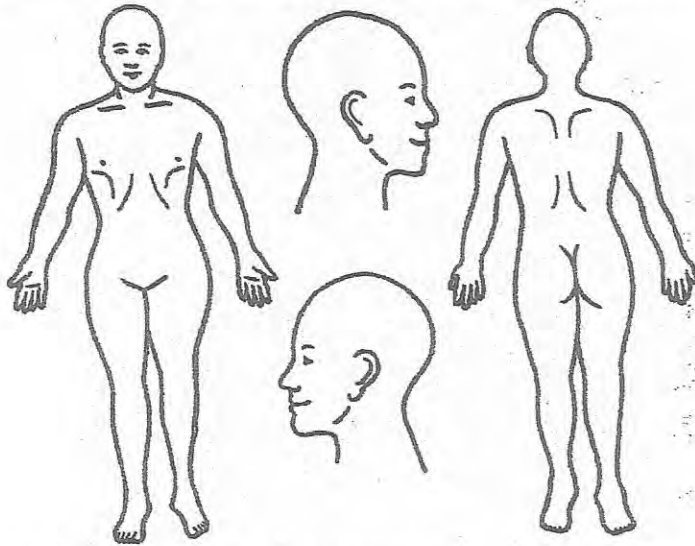
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home Cell

Other: \_\_\_\_\_

Parent/Guardian permission to examine, x-ray and treat minor: X \_\_\_\_\_

**HOP: REASON FOR THIS VISIT**

Please use the following symbols and mark on the diagram below the location(s) of your discomfort:



- XXX Burning
- ((( Aching
- 000 Pins & Needles
- ::: Numbness
- Sharp

**For Office Use Only**

- Constant
- Intermittent
- Getting Worse
- Getting Better
- Not Changing

Better		Worse
<input type="checkbox"/>	AM	<input type="checkbox"/>
<input type="checkbox"/>	Midday	<input type="checkbox"/>
<input type="checkbox"/>	PM	<input type="checkbox"/>
<input type="checkbox"/>	Night	<input type="checkbox"/>

Please indicate the intensity of your symptoms:

0 1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable

Describe the reason(s) for this visit: \_\_\_\_\_

Is the purpose of this appointment related to:  Wellness Care  Work Related Injury  Auto Accident/Personal Injury  
 Sports Injury  Other: \_\_\_\_\_

When did the symptoms begin? \_\_\_/\_\_\_/\_\_\_ How did the symptoms begin? \_\_\_\_\_

What daily activities are painful, difficult or limited because of the symptom(s)?  Sleep  Work  Daily Routine  
 Other: \_\_\_\_\_

What makes the symptom(s) **better**?  
 Ice  Heat  Postural Changes  
 Other: \_\_\_\_\_

What makes the symptom(s) **worse**?  
 Certain Movements  Sitting  Standing  Walking  
 Bending  Lifting  Other: \_\_\_\_\_

Does it cause pain to cough/sneeze?  Yes  No If yes, where is the pain located? \_\_\_\_\_

Have you experienced these symptoms before?  Yes  No

Who have you seen before for symptoms?  No one  Medical Doctor  Chiropractor  Physical Therapist  
 Other: \_\_\_\_\_

**QUESTIONS FOR HEADACHES & NECK**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Y                        | N                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience nausea, vomiting or visual disturbances?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have painful or cracking jaw?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have abnormal blood pressure?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a family history of headaches?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a neck injury that affects hearing, vision, balance or ringing in your ears? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you hear grating sounds?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a feeling of ripping or tearing?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sleep with a pillow?  |
- Frequency of headaches:  everyday OR \_\_\_ times per  week  month  
 What position do you sleep in?  Back  Side  Stomach  
 Date of last exam by an eye doctor: \_\_\_/\_\_\_/\_\_\_

**QUESTIONS FOR LOW BACK**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Y                        | N                        |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a feeling of ripping or tearing? If so, where is it located? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Does pain radiate into the abdomen?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have impairment of bowel/urinary function? If so, explain: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Does it cause pain to cough, grunt or sneeze? If so, where is it located? _____ |

**HEALTH RELATED**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Y                        | N                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent weight changes?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent changes in diet?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have night sweats?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bruise easily?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have fever of long duration?                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or chew tobacco? # of packs per day ____; # of years ____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink coffee, soda or tea? # of caffeinated drinks per day ____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? Type: _____ Days per week: ____             |
- Do you wear:  Heel Lifts  Orthotics  Braces/Supports

**YOUR CONCERNS: SYSTEMS REVIEW**

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Crohn's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain/Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Issues
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Issues
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Problems
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Hand Pain or Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Middle Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Issues	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/Upset Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

**FOR WOMEN ONLY**

<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, due date: ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control?
<input type="checkbox"/>	<input type="checkbox"/>	Do you experience painful periods?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have regular menstrual cycles?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have breast implants?
Date of last gynecological and breast examination: ____/____/____		
Date of last colonoscopy: <input type="checkbox"/> N/A ____/____/____		
Complications, abnormalities, new diagnoses: _____		
Primary Care Physician: _____ @ _____		

**FOR MEN ONLY**

Date of last prostate exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last colonoscopy:  N/A \_\_\_\_/\_\_\_\_/\_\_\_\_

Complications, abnormalities, new diagnoses: \_\_\_\_\_

Current prostate issues: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ @ \_\_\_\_\_

**PAST MEDICAL HISTORY**

Thinking back to childhood and moving forward to the present, please list any injuries, accidents, falls, surgeries and/or hospitalizations:

Type	Area	Treatment	Complications

**MEDICATIONS**

Please check all that apply:

<input type="checkbox"/> Cholesterol Meds	<input type="checkbox"/> Depression Meds	<input type="checkbox"/> Muscle Relaxers
<input type="checkbox"/> Blood Pressure Meds	<input type="checkbox"/> Anxiety Meds	<input type="checkbox"/> Stimulants
<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Insulin	<input type="checkbox"/> Pain Killers
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Vitamins/Supplements: _____		

**FAMILY HISTORY**

Please indicate if any immediate family member has any of the following:

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lupus	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

**CHIROPRACTIC EXPERIENCE**
 Y     N    Have you been adjusted by a chiropractor before?

Approximate date of last treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous chiropractic treatment (check all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Manual Adjustments     | <input type="checkbox"/> Electrical Muscle Stimulation | <input type="checkbox"/> Decompression/Traction |
| <input type="checkbox"/> Activator Adjustments  | <input type="checkbox"/> Ultrasound                    | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Drop Table Adjustments | <input type="checkbox"/> Cold Laser                    | <input type="checkbox"/> Other: _____           |

**GOALS FOR YOUR CARE**

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for the corrections of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Wellness Care**—Bringing whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- Corrective Care**—Correcting and relieving the cause of the problem as well as the symptom.
- Acute Care**—Symptomatic relief of pain or discomfort.

**PATIENT HEALTH INFORMATION INFORMED CONSENT**

We at *The Connection* want you to know your Patient Health Information (PHI) is going to be used in this office and your rights concerning these records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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 the consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to these restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: X \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian Signature: X \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

D.C. Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR OFFICE USE ONLY:**

Additional Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Goals: 1) \_\_\_\_\_ 3) \_\_\_\_\_

                  2) \_\_\_\_\_ 4) \_\_\_\_\_