Welcome To TRU Health Family Chiropractic

First Name _____ MI ____ Last _____ Birth Date____/____/____ Age_____ Today's date____/____/_____

Address _____City _____ State_____ Zip _____

Cell # ( )_____ Male ____ Female ____ E-mail Address _____

# of Children _____ Ages of Children _____ Marital Status: ___Single ___Married ___Significant Other ___Widowed ___Separated ___Divorced

Emergency Contact _____ Emergency Contract # ( )_____ **Pregnant (Female Only)** Yes ___ No___ How far along ___

How did you hear about us? _____ Method of payment: *FSA HSA Cash Check CC*

What health condition(s) brings you into our office? _____ _____

_____ _____ _____

Have you received care for this problem before? _____ _____

When did the problem start? _____ How did the problem start? ___Suddenly ___Gradually ___Post-Injury

Is this condition: ___Getting Worse ___Improving ___Intermittent ___Constant ___Unsure

Describe the pain: (circle all that apply)

Burning Diffuse Dull/Aching Localized Radiating

Sharp Shooting Stabbing Tingling Other_____

What makes the problem better? _____ _____

What makes the problem worse? _____ _____

Medications: What Medications are you currently taking and for what conditions?_____

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers) R/L or Both
___Headaches/Migraines
___Fractured Bones
___Swollen Painful Joints
___Anemia
Pain w/ Cough / Sneeze
___Heart Problems
___Prostate Problems
Dizziness/Vertigo
___Fatigue
___Colon Trouble
___Cold feet
Foot Problems
___Cold Sweats
___High Blood pressure
___Extended Sit/Stand
___Car Accident

___Hip Pain R / L
___Arthritis
Convulsions/Epilepsy
___Tremors
Chest Pain
___Stroke
___Kidney Trouble
Buzzing/Ringing in ears
Depression
Sleeping Problems
Bed Wetting
Shortness of Breath
___Cancer (Type)
_____
PMS
___Work Injury
Slips/Falls

___Numbness,Tingling or Pain (Butt/Thigh/Leg/Feet/Toe) R/L or Both
___Neck Stiffness/ Pain
Frequent Colds / Flu
___Skin Problems
Blurred Vision R / L
___Lung Problems
___Gall Bladder Problems
___Loss of Smell
___Sinus Problems/Allergies
___ Irritability/Mood Swings
___Cold Hands
___Recurring Infection
___Hot Flashes
Problems Urinating
___Menopause
___Poor Posture

___Back Stiffness/Pain
Diabetes
___Smoking
Double Vision R / L
Loss of Taste
___Digestive Problems
___Loss of Balance
___Nervousness/Anxiety
___Tension/Stress
___Stomach Upset
___Diarrhea/Constip/Gas
___Jaw/TMJ Problems
Heartburn/Reflux
___Ulcers
Sports Injuries

WHAT ARE YOUR GOALS?

IMMEDIATE:	SHORT TERM:	LONG TERM:

PATIENT FINANCIAL OBLIGATION AGREEMENT:

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to TruHealth Family Chiropractic for services rendered. I authorize representatives of TruHealth Family Chiropractic to release pertinent medical information to my insurance company when requested or to facilitate a payment of a claim.

I read and agree to the above:

Patient Signature: _____ Date: _____