CONFIDENTIAL PATIENT INFORMATION Patient ID #: _____

First Name: _____ MI: _____ Last Name: _____ Sex: ☐ Male ☐ Female

Age: _____ DOB: _____ Marital Status: ☐S ☐M ☐D ☐W Name of Spouse: _____

Home Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone _____

Whom may we thank for referring you to our office: _____

Purpose of this appointment: _____

_____

How did the problem start? ☐Suddenly ☐Gradually ☐Post-Injury ☐Other: _____

Is this condition: ☐Getting worse ☐Improving ☐Intermittent ☐Constant ☐Other: _____

List all medications or drugs you are currently taking? _____

Have you seen other doctors for this condition? ☐Yes ☐No Doctor's Name: _____

Have you ever received Chiropractic care before? ☐Yes ☐No Doctor's Name: _____

How long under care? _____ Date of last visit: _____ Why did you stop? _____

_____

Have you ever had any significant falls, surgeries, or other injuries as an adult? ☐Yes ☐No If yes, please explain: _____

_____

_____

Notable childhood injuries? ☐Yes ☐No If yes, please explain: _____

_____

Any auto accidents? ☐Yes ☐No If yes, please explain: _____

_____

Remarks and additional information: _____

_____

_____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Patient's Signature _____ Date: _____

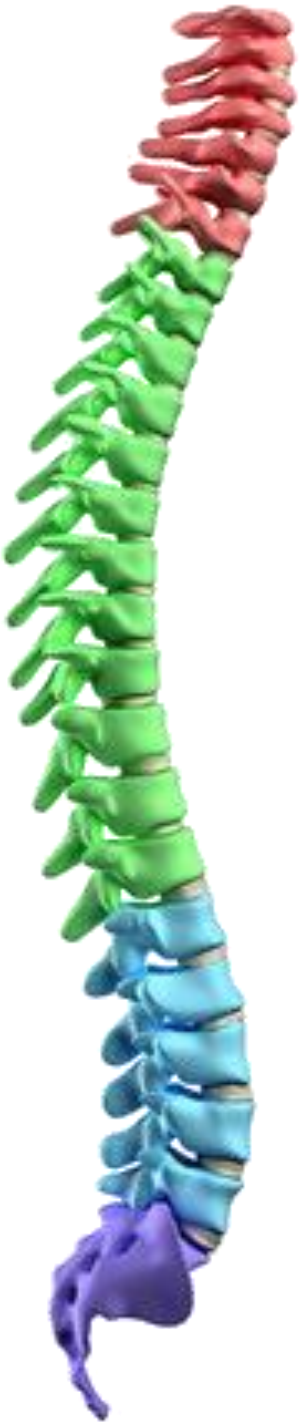
Signature of Parent/Guardian: _____ Date: _____

Information Taken By: _____ Date: _____

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS	
		PAST PRESENT	PAST PRESENT
Cervica	• Automatic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response Filtration & • Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. • (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Gluten & Casein Intolerance	☐☐ Constipation ☐☐ Chrohn's. Colitis & IBS ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Weak Ankles & Arches ☐☐ Hemorrhoids ☐☐ Low Back Pain

Patient Name: _____ Patient Signature: _____ Date: _____

OUR MISSION IS TO PROVIDE THE HIGHEST QUALITY AND AFFORDABLE CHIROPRACTIC CARE. WITH DEDICATION, WE PROMOTE A BETTER QUALITY OF LIFE.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: *to locate, analyze, and correct spinal interference to the nervous system (nerve pressure).* The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (*spinal misalignment producing nerve interference),* in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment, allows the body to function at its optimum level. This allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustment and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts that is known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

Patient's Signature: _____ **Date:** _____

Guardian/Spouse's Signature: _____ **Date:** _____

Indicate relationship to patient:_____

FEMALES ONLY

Are you pregnant? Y N

If x-rays are recommended, your signature is required (below) to indicate that you are NOT pregnant.

Signature: _____ Date: _____