



COMPLETE HEALTH CHIROPRACTIC

WELCOMES YOU

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ABOUT YOU

Today's Date _____ File #: _____

Patient Name _____
LAST FIRST MI

What You Prefer To Be Called _____ Male Female

Birth-date: _____ Age: _____ SS#: _____

Mailing Address: _____

Home Phone#: (_____) _____

Work Phone#: (_____) _____ Ext: _____

Cell Phone#: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How Many? _____

IN CASE OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

CONTRACT

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Client Signature: _____

Date: _____

PLEASE CONTINUE ON BACK



REASON FOR VISIT

Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness
 Are you in pain: Yes No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
 Did your injury occur during: Work Sports/play Auto accident Routine/household activity

When did your condition/accident occur? _____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes.

Is your condition interfering with your: Work Sleep Daily routine? Is so, how: _____

Has this or something similar happened in the past?

Yes No Explain: _____

Using the adjacent body charts, please circle all affected areas.

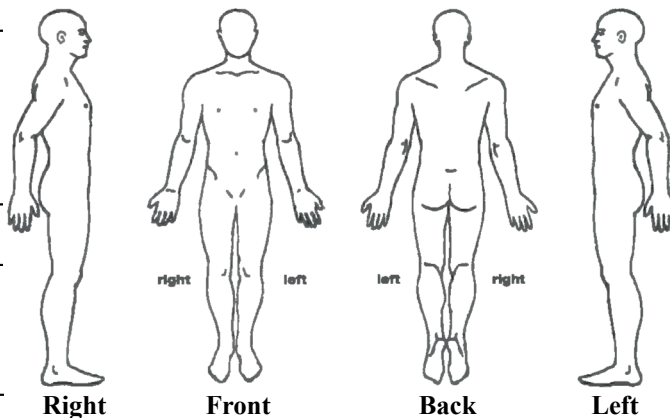
Have you been treated by a Medical Physician for this condition? Yes No If so, where? _____

Have you ever been treated by a Chiropractor?

Yes No

Clinic or Dr's name: _____

Clinic Phone #: _____



HEALTH HISTORY

Are you taking any of the following medications? Nerve pills Pain killers(including aspirin) Muscle relaxer Blood thinners

Tranquilizers Insulin Others(s) _____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

- | | | | | |
|------------------------------------|---------------------------------------|--------------------------------|---|----------------------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N HIV + / AIDS / ARC |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Anemia / Diabetes |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe / Frequent Headaches | Y N Kidney Problems |
| Y N Ulcers/ Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma | Y N Tuberculosis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes, How much? _____ How long? _____

Are you wearing: Shoe Lifts Inner soles Arch supports Are you dieting: No Yes, Since: _____

For woman: Are you taking Birth Control? Yes No

Are you Nursing? Yes No Are you Pregnant? No Yes, If so, how many weeks? _____