

# ABOUT THE PATIENT

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender  M  F  
 Significant Other's Name \_\_\_\_\_ Kid's Names and Ages \_\_\_\_\_  
 Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before?  No  Yes  
 Emergency Contact \_\_\_\_\_ ph # \_\_\_\_\_  
 Name of Medical Doctor(s) \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Natural Ways to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:  Cash  Check  Credit Card  Car/Work Ins.

\_\_\_\_\_  
 Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

# REASON FOR SEEKING CARE

## PRESENT COMPLAINTS

1. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

2. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

3. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

4. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

5. Does your condition affect:  Sleep  Work  Daily Routine  Sitting  Driving

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

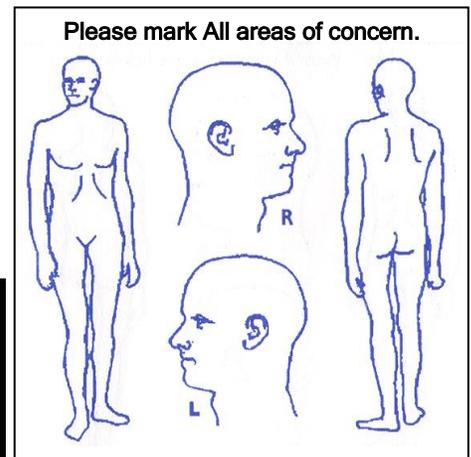
8. What Doctor's have you seen for this? \_\_\_\_\_

9. Type of treatment: \_\_\_\_\_

10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_

**Are you pregnant?**  
 Yes  No



# GENERAL HEALTH HISTORY



Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

**Past Present**

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other \_\_\_\_\_

**Past Present**

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- \_\_\_High or \_\_\_Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications are you taking: \_\_\_\_\_
2. Please list all doctors you are currently seeing: \_\_\_\_\_
3. Has any Doctor or other professional advised you to "Go to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

4. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_
5. List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_
6. List any past sport, recreational, or home injuries \_\_\_\_\_
7. Please describe any past conditions and treatment received: \_\_\_\_\_
8. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

- Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Is there any other family history you want us to know? \_\_\_\_\_