

REASON FOR SEEKING CARE

Name	Today's Date	Birthdate	Age
Address	City	State	Zip
Home Phone	Marital Status		
Cell Phone	Spouse Name		
Work Phone	Number of Children		
E-mail	Your Employer		
Have you been to a chiropractor before? <input type="checkbox"/> No <input type="checkbox"/> Yes	Occupation		
Who referred you to our office?			
Emergency Contact	Phone #		
Name of Medical Doctor(s)			

- 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.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- I acknowledge that I was provided a copy of the [Notice of Privacy Practices](#) for Desired Health Chiropractic. I have read and understand them, or declined the opportunity to read them.
- I understand that the possible risks of chiropractic care are considered very rare, but may include strains, sprains, dislocations, injury to intervertebral discs, nerves or spinal cord, or cerebrovascular incident.
- I authorize the doctor or staff to render care as deemed appropriate for me and / or my child.

Patient / Guardian Signature (This represents a long term authorization for all occasions of service)

Date

PRESENT COMPLAINTS

Briefly describe your symptoms:

How did your symptoms start?

When did your symptoms start?

How long has this been an issue?

What makes it better?

What makes it worse?

Any previous treatment for this?

Results:

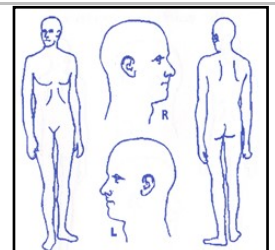
Please mark **ALL** areas of concern

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

Rate your pain on a scale of 1 (no pain) to 10 (unbearable pain): 1 2 3 4 5 6 7 8 9 10

Does your condition affect: Sleep Work Daily Routine Sitting Driving Lifting

Have you had similar accidents or injuries before? No Yes



YOUR HEALTH GOALS

What specific health goals do you have?

(Examples: Working out, vacation/trip, activities with family/kids)

How will you know that you have reached this goal?

(Examples: Run a 5K, garden 3 times a week, sitting for more than 2 hours)

1.

1.

2.

2.

3.

3.

GENERAL COMPLAINTS

Name _____

Today's Date _____

Mark the conditions that apply to you:

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		Headaches			Sleeping Problems			Gall Bladder Trouble
		Migraines			Fainting			Thyroid Problems
		Vision Problems			Easy Bruising			Liver Disease
		Light Bothers Eyes			Ear Problems			Kidney Problems
		Asthma			Alcohol Use			Urinary Problems
		Allergies			Tobacco Use			Digestive Problems
		Diabetes			Dental Problems			Heart Problems
		Hands or Feet cold			TMJ Issues			Heart Pacemaker
		Leg / Foot Numbness			Cancer _____			Chest Pains
		Muscle Aches			HIV Positive			Shortness of Breath
		Trouble Walking			___ High or ___ Low Blood Pressure			Blood Thinner use
		Fibromyalgia			Medication Side Effects			Stroke History
		Pain all Over			Tension / Irritability			High Cholesterol
		Other _____			Depression			Pregnancy (Females Only)

Current Height : _____

Current Weight: _____

List any medications you are taking: _____

Please list all doctors you are currently seeing: _____

Has any Doctor advised you to "Go to a Chiropractor" No Yes

Name: _____

PAST HISTORY

List any past auto collisions: _____

Was any care received? _____

List any past work injuries: _____

Was any care received? _____

List any past sport, recreational, or home injuries: _____

Please describe any past conditions and treatment received: _____

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? _____