Welcome to our

Family Chiropractic Office

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy, life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during the Doctor's Report.

We look forward to a long, healthy relationship with you and your family.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____/____/____ (signature) (date)

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General Information

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

Address_____ City_____ State_____ Zip_____

Home # ( )_____ Work # ( )_____ Ext._____ Soc. Sec. #_____-_____-_____

Fax # ( )_____ Cellular # ( )_____ E-mail Address _____

Are you pregnant? No ____ Yes ____Occupation_____ Employer _____

Employer's Address_____ City_____ State_____ Zip_____

____Male ____Female # of Kids_____ □ Single □ Married □ Widowed □ Separated □ Divorced Name of Spouse _____

Names and Ages of Kids_____ Who referred you to our office? _____

Insurance Information

	PRIMARY INSURANCE	SECONDARY INSURANCE
Your **relation** to Insured:	┐Self ┐Spouse ┐Child ┐Other	┐Self ┐Spouse ┐Child ┐Other
Complete the following Insured information if *RELATION* is other than *SELF*		
Insured's Name:		
Insured's Birthdate:		
Male or Female:		
Complete the following Insured information if it *differs* from the Patient's		
Insured's Address:		
City, State, Zip:		
Phone Number:	( )	( )

Your Health Profile

Why this form is important – As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a **lifetime** of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine your true health potential.

The Beginning Years – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History – Please check those items that apply to you ____Mother smoked/drank/drugs in pregnancy ____Epidural/Meds in labor ____Breech Vaginal Delivery ____C-Section ____Forceps Delivery ____Vacuum Extractor used ____Labor Induced ____Complications ____Other_____

Childhood Years (Age 0-17 yrs) – Please check those items that apply to you ____Childhood Illness ____Serious Falls ____Active in Sports ____Very Inactive ____Car Accident(s) ____Surgery/Stitches ____Alcohol/Drug Abuse ____Smoker ____Antibiotics/Other Meds ____Vaccinated ____Under Chiropractic care ____Broken Bones ____ Emotional Trauma(s) ____ Other Injuries _____

Adult Years (Age 18 to present) – Please check those items that apply to you ____Present Smoker ____Former Smoker ____OTC/Prescription Meds ____Alcohol Use ____High Job Stress ____Surgery/Stitches ____Play Sports ____Car Accidents ____Work Injury ____High Personal Stress ____Sit a lot ____Drive a lot ____Poor Sleep ____Not Enough Sleep ____Poor/Inadequate Diet ____No Exercise ____Flat Feet ____Wear Orthotics/Lifts ____Severe Health Problems ____Hard Falls ____Broken Bones ____Flu Shots ____Other Injuries

_____

____Have been under chiropractic care in the past. How long ago was your last adjustment?_____

Addressing the issues that brought you to our office

If you have no symptoms or complaints and you are here for chiropractic wellness services, please check here ____ and skip to "**Family Health Profile"** near the bottom of this form. Otherwise, please continue directly below.

***Please check if you are here for any of the following:* _____Motor Vehicle Accident _____Work Injury _____Other Injury**

Chief Complaint(s): _____

How has this affected your life? _____

If you have pain, at it's worst is it…____Sharp ____Dull ____Constant ____Intermittent ____Traveling
____Mild ____Moderate ____Severe ____Intolerable
Since it began, is it… ____Unchanged ____Getting Better ____Getting Worse ____Variable
What makes it worse? _____
What makes it better? _____
Does it interfere with… ____Work ____Sleep ____Walking ____Sitting ____Exercise ____Hobbies ____Leisure Activities
Did you have an injury? ____Yes ____No If Yes, please explain_____

How long have you had this problem? _____
Is there a time of day that it is worse typically? ____Yes ____No If Yes, when? _____
Other doctors/treatments you've tried for this problem (Please list): _____
Chiropractor_____
Medical Doctor _____
Other _____

Please check all recurring or severe symptoms you have ever had, even if they do not seem related to your current problem(s).

___Headaches/Migraines ___Pins & Needles in Legs/Feet ___Recurring Infection ___Infertility/Impotence/Miscarriage ___Pins & Needles in arms
___Loss of Smell ___Back Stiffness/Pain ___Loss of Balance ___Dizziness/Vertigo ___Buzzing/Ringing in ears ___Sinus Problems/Allergies
___Nervousness/Anxiety ___Numbness in fingers ___Numbness in toes ___Loss of Taste ___Stomach Upset ___Fatigue ___Depression
___ Irritability/Mood Swings ___Tension/Stress ___Sleeping Problems ___Neck Stiffness/Pain ___Cold Hands ___Cold feet ___Diarrhea/Constip./Gas
___Foot Problems ___Shortness of Breath ___Hot Flashes ___Cold Sweats ___Light Bothers Eyes ___Problems Urinating ___Heartburn/Reflux
___High Blood pressure ___Pre-Menstrual Syndrome (PMS) ___Menopause ___Ulcers ___Jaw/TMJ Problems
___Other_____

Family Health Profile

In our office, we are not only interested in *your* health & well being, but also in that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children_____
Spouse_____
Parents_____
Siblings_____
Others_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

_____ _____/_____/_____ Signature Date