

PATIENT INFORMATION

Name (First and Last)		Date of Birth		Age	Today's Date
Address		City		State	Zip
Gender	Marital Status		Spouse's Name	Occupation	
Cell Phone		Home Phone		Email Address	
In Case of Emergency, Contact:			Phone		Relationship
How did you hear about us?					

PATIENT CONDITION

Primary Reason for Visit:

When did your symptoms appear?

What was going on in your life when your symptoms first appeared?

How often do you have your symptom(s)? _____ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness
☐ Swelling ☐ Other: Describe _____

Where is it located (be specific as possible):

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Activities ☐ Recreation ☐ Other :

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Secondary Reason for Visit:

When did your symptoms appear?

What was going on in your life when your symptoms first appeared?

Provide any additional details about this symptom:

LIFE STRESS ASSESSMENT

Have you experienced stress in any of the following areas in the last 6 months? (check all that apply)

☐ Relationships ☐ Money ☐ Work/School ☐ Physical Health ☐ Mental Health ☐ Other

If you would like to provide additional details (optional):

MEDICATIONS / SUPPLEMENTS

MEDICATIONS	WHAT IS THIS MEDICATION FOR?	SUPPLEMENTS (VITAMINS/MINERALS/HERBS)

HEALTH HISTORY

What health concerns are you being treated by a health professional for?

What treatments have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other:

Has anything helped this condition improve?

Date of Last (if known):

Physical Exam:

Spinal X-Ray:

MRI, CT-Scan, Bone Scan:

Dental X-Ray:

Chest X-Ray:

☐ Blood Test ☐ Vitamin D ☐ Cholesterol ☐ Fasting Glucose ☐ Urine Test ☐ Other

Are you pregnant? Yes ☐ No ☐ Due Date: Date of Last Menstrual Period:

INJURIES / SURGERIES

Please describe the incident or surgery and date it occurred.

Falls:

Head Injuries:

Surgeries:

HEALTH HISTORY

EXERCISE	WORK ACTIVITY	HABITS	Little	Moderate	Lots
Amount	Sitting	Smoking:	☐	☐	☐
Type	Type of Work	Alcohol:	☐	☐	☐
Do you enjoy it?	Light ☐ Heavy ☐	Stress:	☐	☐	☐

I confirm the information provided is true to the best of my ability.

Signature **X**

Date _____

TERMS OF ACCEPTANCE

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

Adjustment: An adjustment is a 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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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 a chiropractic spinal examination, 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 goal is to eliminate any major interference to the expression of the body's innate wisdom. Our method is by specific adjustments of the spine to correct vertebral subluxations.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I therefore accept care on this basis. **Initial:** _____

Notice of Privacy Practices:

I acknowledge that I have read and understand Mind Body Health & Chiropractic's "Notice of Privacy Practices" and that I am aware that a copy of the notice can be obtained from the doctor or his staff. **Initial:** _____

Optional Disclosure Authorization:

I hereby request that the below listed person(s) be given permission for the following purposes on my behalf:

(check all that apply)

- ☐ Scheduling/changing/confirming appointments
☐ Bill payment/insurance

☐ Medical records/health information permission

☐ Other (specify) _____

Name of authorized person(s): _____

For Chiropractic Care X-ray Imaging:

Pregnancy Release (if applicable):

This certifies that to the best of my knowledge **I am not pregnant**, and the doctor and his associates have my permission to perform X-ray evaluation, if needed. I have been advised that X-ray can be hazardous to an unborn child. **Initial:** _____

Consent to evaluate and adjust a minor child (if applicable):

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. **Initial:** _____

Please sign and date below that you have read, understood, and agree to the above notices.

X _____
Signature

_____/_____/_____
Date