Primary complaint / purpose of this appointment: _____

_____

Secondary complaint(s): _____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other

How long has it been since you really felt well? _____

What do you believe is wrong with you? _____

Have you seen other doctors for this condition? ☐ Yes ☐ No If yes, who? _____

Have you been treated for any health conditions by a physician in the last year? ☐ Yes ☐ No

If yes, describe: _____

List medications and/or drugs that you are currently taking: _____

Primary care physician's name: _____ Address: _____

Send a report? ☐ Yes ☐ No

Any additional information? _____

_____

PLEASE NOTE THAT PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Are you insured? ☐ Yes ☐ No Company _____

If patient is a dependent, insured name _____ SS# _____ DOB _____

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

I certify that, to the best of my knowledge, the above information provided is correct, and I will be able to abide by the terms and agreement.

Patient's signature _____ Date _____

Guardian or Spouse's signature authorizing care _____ Date _____

STAFF ONLY:

Additional notes _____

_____

_____

ALTERNATIVE HEALING CHIROPRACTIC PLLC

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ S.S. # _____ Phone # _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Age _____ DOB (MM/DD/YYYY) _____

Marital: M S W D How many children? _____ Occupation _____ Employer _____

Employer Address _____ Office Phone _____ Ext. _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Address: _____

Emergency Contact Person _____ Address: _____ Phone: _____

Referred by _____

Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No If yes, date of accident: _____

Have you ever had a same or similar condition? ☐ Yes ☐ No If yes, when? Describe. _____

Have you missed any days from work? ☐ Yes ☐ No If yes, how many? _____

Date of last physical examination: _____ Past surgeries (include date): _____

Serious illnesses (include date) _____ Previous bone fractures _____

Females only: are you pregnant? ☐ Yes ☐ No

Have you ever been under chiropractic care? ☐ Yes ☐ No Doctor's name: _____

Have you ever suffered from...

- ☐ Allergies
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Ulcers
- ☐ Nervousness / depression
- ☐ Arthritis
- ☐ Foot trouble
- ☐ Low back pain
- ☐ Neck pain or stiffness

Numbness or tingling in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvatures
- ☐ Swollen joints
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Asthma
- ☐ Frequent colds
- ☐ Deafness
- ☐ Ear noises (i.e. ringing)
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Autoimmune disease

- ☐ Tuberculosis
- ☐ Easy bruising
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus infections
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Anemia
- ☐ Stroke
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Pleurisy
- ☐ Poor circulation
- ☐ Varicose veins

- ☐ Itching
- ☐ Bed wetting
- ☐ Frequent urination
- ☐ Kidney stones / infection
- ☐ Prostate trouble
- ☐ Severe menstrual cramps
- ☐ Heavy menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycles
- ☐ Lumps in breast
- ☐ Alcoholism
- ☐ Sexually transmitted disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Swelling of ankles
- ☐ Polio
- ☐ Other

If other, please specify: _____

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

DO YOU:

Take vitamins or minerals? ☐ Yes ☐ No

Think you may need vitamins or minerals? ☐ Yes ☐ No

Are you wearing:

☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports