

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Social Security #: _____ Age: _____ Male Female
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone: _____
How many children: _____ ages: _____ Emergency Contact: _____
Your Occupation _____ Your Employer: _____
Referred to this Office by: Friend/Family Member – Name: _____
 Yellow Pages Mail Clinic Location Other _____

HISTORY OF PRESENT ILLNESS

What are your **primary complaints**? Please Rate Your Pain/Discomfort on a scale of 0-10. 0=none 10=worst

1. _____ Rate Symptoms: _____
2. _____ Rate Symptoms: _____
3. _____ Rate Symptoms: _____
4. _____ Rate Symptoms: _____
5. _____ Rate Symptoms: _____
6. _____ Rate Symptoms: _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

DATE OF ONSET: _____ HOW DID THIS CONDITION DEVELOP? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT
 ILLNESS UNKNOWN CAUSE GRADUAL ONSET

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT NEARLY CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES, WHEN? _____

DO WORK ACTIVITIES AGGRAVATE YOUR CURRENT COMPLAINTS? YES NO

WHICH WORK ACTIVITIES? _____

DATES MISSED FROM WORK: _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
 LIFTING SNEEZING WALKING LYING DOWN STANDING OTHER _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING
- OTHER _____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss/confusion
- constipation depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset
- other _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Other conditions: _____ Do you have a history of Stroke or Hypertension? Yes No

Father: living, age: ___ deceased, cause: _____

Mother: living, age: ___ deceased, cause: _____

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

Describe Condition _____ Date of Last Physical Exam _____

Who is your physician? _____ Address: _____

May we have permission to update your medical doctor regarding your care at this office? Yes No

Name and location of doctors previously seen for present condition(s): _____

Have you ever been treated by a Chiropractor? NO YES, Who/Where? _____

Any X-rays, MRI OR CAT SCANS been taken recently? NO YES When/Where? _____

Any Drug Allergies? NO YES, What kind? _____

Are you currently taking any medication: NO YES, What kind? _____

Are you pregnant? NO YES Date of last menstrual period: _____

SURGICAL HISTORY:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Have you ever had a metal implant? Yes No ever was gunshot? Yes No

ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____

Job Auto Other 2. _____ Date: _____

Job Auto Other 3. _____ Date: _____

(Over please)

SOCIAL HISTORY:

Do you drink alcoholic beverages? No Yes, how much per week? _____

Do you use any tobacco products? No Yes Do you smoke? No Yes, how many packs, per day?

Do you take vitamin supplements? No Yes, please list: _____

Do you consume caffeine? No Yes, how much per day? _____

Do you exercise? No Yes, what is the frequency and type of exercise? _____

What percentage of time during the day (at home or work) do you spend: lifting____ sitting____ bending ____
computer_____

Payment for Services will be by: Cash Check Credit Card Health Insurance
Automobile Insurance Worker's Compensation

Name of Primary Insurance Company.: _____

Insured's Employer: _____ Insured's Social Security #: _____

Employer's Phone #: _____

Are you covered by more than one insurance company? Yes No

Name of Secondary Insurance Company: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to AQUI CHIROPRACTIC CLINIC, LLC. I authorize AQUI CHIROPRACTIC CLINIC, LLC to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____