# Hope Chiropractic

"Giving you hope, improving health, creating wellness!"

## ABOUT THE PATIENT

Date: ________________
Name: ______________________________ Birth date ________________________ Age: ________________
Address: ____________________________ City: ________________ State: ____________ Zip: ___________
Cell #: _________________ Home #: __________________ Work #: ___________________
E-mail Address: ___________________________________________________ SS#: ______________________
Employer: ___________________________________ Occupation: ____________________________________
Marital Status: □ Married □ Single □ Separated □Divorced □ Widowed
How many children do you have? ___________________
Name (s) & Age (s) ____________________________________________________________________________
Family M.D. Clinic: ________________________________________________________________________

## ABOUT THE SPOUSE / PARENTS / EMERGENCY CONTACT

Name (s): ____________________________________ Cell Phone: ___________________________________
Employer: ____________________________________ Occupation: ___________________________________

## REASON FOR THIS VISIT

Describe the purpose for this visit: ______________________________________________________________
When did this health challenge begin? ____________________________________________________________
Has this: □ gotten worse □ stayed the same □ comes and goes □ gotten better
Does this interfere with: □ work □ sleep □ daily routine □ other activities (___________________________)
Has this condition occurred before? □ Yes □ No Explain: ____________________________________________
Have you seen any other professional for this? □ Yes □ No; Dr.'s Name (s) _____________________________
Type of treatment ____________________________________ Results _________________________________
Is the purpose for this visit related to:
□ Job □ Auto □ Fall □ Sports □ Daily Life □ Chronic Discomfort □ Home Injury □ Other;
Please explain: ___________________________________________________________________________
If job related, have you made a report of accident to your employer? □ Yes □ No

## EXPERIENCE WITH CHIROPRACTIC

How did you hear about our office? ______________________________________________________________
Have you been adjusted by a chiropractor before? □ Yes □ No
Reasons for those visits? _____________________________________________________________________
Approximate Date of Last Visit: ____________________ Previous Chiropractor's Name: _____________________
Has an *adult* in your family seen a Chiropractor? □ Yes □ No
Has a *child* in your family seen a Chiropractor? □ Yes □ No

## AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that...

- Doctors of Chiropractic work with the nervous system? □ **Yes** □ **No**
- the nervous system controls all bodily functions and systems? □ **Yes** □ **No**
- Chiropractic is the largest natural healing profession in the world? □ **Yes** □ **No**
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? □ **Yes** □ **No**

## GOALS FOR CARE

People see Chiropractors for a variety of reasons. Some go for pain relief, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. **Please check** the type of care desired so that we may be guided by wishes whenever possible.

□ **Relief Care:** Symptomatic relief of pain or discomfort

□ **Corrective Care:** Correcting and relieving the **cause** of the problem as well as the symptoms.

□ **Comprehensive Care:** Caring for the whole body not just the symptomatic area. This works on achieving the highest state of health in your body.

□ I want the Doctor to select the type of care appropriate for my condition and recommend care that will be the best for my health and wellness.

## PERSONAL HISTORY

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical, or emotional may cause **subluxations**. The practice of Chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxation**.

## CURRENT MEDICATIONS

______________________________________________________________________

______________________________________________________________________

## HEALTH HABITS

| | No | Yes | |
|---|---|---|---|
| Do you smoke? | ☐ | ☐ | _____ packs per day |
| Do you drink alcohol? | ☐ | ☐ | _____ drinks per week |
| Do you drink coffee/soda? | ☐ | ☐ | _____ cups per day |
| Do you exercise? | ☐ | ☐ | ☐ Mild ☐ Moderate ☐ Daily |
| Do you wear Heel Lifts? | ☐ | ☐ | |
| Do you wear Arch Supports? | ☐ | ☐ | |

| **For Women:** | No | Yes |
|---|---|---|
| Are you pregnant? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |
| Are you taking birth control? | ☐ | ☐ |
| Do you have painful periods? | ☐ | ☐ |
| Do you have irregular Cycles? | ☐ | ☐ |

## HEALTH CONDITIONS

Please tell us of any past/current diseases or conditions. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT

| | No | Yes | Explain: |
|---|---|---|---|
| 1.) Car Accident? | ☐ | ☐ | ____________ |
| 2.) Work Injuries? | ☐ | ☐ | ____________ |
| 3.) Sports Injuries? | ☐ | ☐ | ____________ |
| 4.) Work Stress? | ☐ | ☐ | ____________ |
| 5.) Family/Home Stress? | ☐ | ☐ | ____________ |
| 6.) Prescription Drug Use? | ☐ | ☐ | ____________ |
| 7.) Ever Hospitalized/Surgeries? | ☐ | ☐ | ____________ |
| 8.) Major Illnesses? | ☐ | ☐ | ____________ |
| 9.) Limited Exercise? | ☐ | ☐ | ____________ |
| 10.) Poor Nutrition? | ☐ | ☐ | ____________ |

## PLEASE TELL US ABOUT ANY STRESS RELATED TO BIRTH/CHILDHOOD

| | No | Yes | Explain: |
|---|---|---|---|
| 1.) Any falls or injuries? | ☐ | ☐ | ____________ |
| 2.) Allergy/Asthma or Respiratory problems? | ☐ | ☐ | ____________ |
| 3.) Ear Infections? | ☐ | ☐ | ____________ |
| 4.) Digestive Problems? | ☐ | ☐ | ____________ |
| 5.) Hyperactivity? | ☐ | ☐ | ____________ |
| 6.) Drugs/medicine/tobacco/alcohol in pregnancy? | ☐ | ☐ | ____________ |
| 7.) Labor chemically induced? | ☐ | ☐ | ____________ |
| 8.) Premature delivery? | ☐ | ☐ | ____________ |
| 9.) Vaccinations? | ☐ | ☐ | ____________ |
| 10.) Any other health related problems? | ☐ | ☐ | ____________ |

## AUTHORIZATION FOR CARE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I hereby authorize the Doctor(s) to work with my condition through the use of adjustments as he/she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsibly for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I authorize release of records to assist collections.

Patient Signature ______________________________ Date: ____________