

Name: _____ Date of Birth: _____ Age: _____
 Your Address: _____ City: _____
 State: _____ Zip: _____ SS #: _____ Cell #: _____
 Name of Employer: _____ Home #: _____
 Marital Status: S M W D Referred By: _____ Email#: _____
 How Many Children Do You Have? _____ What Are Their Ages? _____
 Have You Or Any Other Members of Your Family Received Chiropractic Care? [] Yes [] No
 How Long Has It Been? _____
 Emergency Contact: _____ Phone #: _____
 Who Is Responsible For Your Bill? [] Self [] Spouse [] Worker's Compensation [] Medicaid
 [] Medicare [] Auto Insurance [] Personal Health Insurance [] Other: _____
 Purpose Or Reason For Today's Appointment? _____
 How Often Do You Drink Alcoholic Beverages? _____
 Do You Smoke? [] Yes [] No How Much? _____
 Do You Exercise? [] Yes [] No How Much? _____ Type? _____
 Do You have Any Allergies? [] Yes [] No Specify: _____

Have you Ever Suffered From or Been Diagnosed As Having: (circle yes or no for each)

- | | |
|--------------------------------|---------------------|
| Y N *Broken or Fractured Bones | Y N Ulcers |
| Y N Circulatory Problems | Y N Ruptures |
| Y N Rheumatoid Arthritis | Y N Coughing Blood |
| Y N Seizures/Convulsions | Y N Osteoarthritis |
| Y N A Congenital Disease | Y N Eating Disorder |
| Y N Excessive Bleeding | Y N Alcoholism |
| Y N High/Low Blood Pressure | Y N Drug Addition |
| Y N Diabetes | Y N HIV Positive |
| Y N Epilepsy | Y N Gall Bladder |
| Y N Pacemaker | Y N *Head Problems |
| Y N Strokes | Y N Depression |
| Y N *Cancer | Y N Tumors |

Explain: _____

Medication List

Name of Medication	Name of Vitamins	Date Started	Date Stopped

Healthcare Provider Team

Other providers seen for the same condition: _____

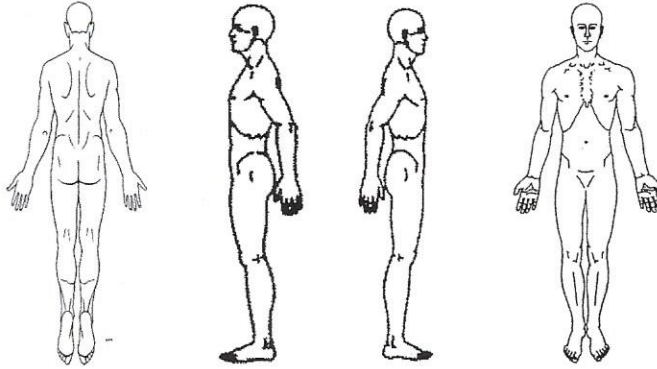
Who is currently your
 Chiropractor: _____
 Primary Care Physician: _____
 Physical Therapist: _____
 Dentist: _____

Massage Therapist: _____
 Personal Trainer: _____
 Acupuncturist: _____
 Health Club: _____
 Other: _____

PATIENT HISTORY

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

- A. Ache
- B. Burning
- C. Cramping
- D. Dull Pain
- F. Stiffness
- N. Numbness
- R. Throbbing
- S. Soreness
- T. Tingling
- X. Sharp Pain



	1 st Complaint	2 nd Complaint	3 rd Complaint	4 th Complaint	5 th Complaint
Complaint:					
When did it start?					
On a scale of 1 -10 1 = mild 5 = moderate 10 = severe Rate your pain levels:	Current:	Current:	Current:	Current:	Current:
	Average:	Average:	Average:	Average:	Average:
	At Best:	At Best:	At Best:	At Best:	At Best:
	At Worst:	At Worst:	At Worst:	At Worst:	At Worst:
What % of the time does it occur?	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100
When does it occur most?	__AM__PM __Night	__AM__PM __Night	__AM__PM __Night	__AM__PM __Night	__AM__PM __Night
How long does it last?	__Minutes__Hours __Days__Constant	__Minutes__Hours __Days__Constant	__Minutes__Hours __Days__Constant	__Minutes__Hours __Days__Constant	__Minutes__Hours __Days__Constant
What makes it better?					
What makes it worse?					

Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

- | | | | | | | | |
|----------|-----|----------|-----|----------|-----|------------|-----|
| Walking | Y N | Kneeling | Y N | Grooming | Y N | Driving | Y N |
| Bending | Y N | Sitting | Y N | Standing | Y N | Exercising | Y N |
| Sleeping | Y N | Lifting | Y N | Running | Y N | Housework | Y N |

1. Have you ever had the condition(s) in the past? Yes No
If yes, please indicate if any treatment was received and what type of treatment:
 Hospitalization Chiropractic care Medical doctor / specialty provider None
2. Have you ever lost time from work due to your condition(s)? Yes No
If Yes, dates? _____
3. Are you pregnant? Yes No
4. What was the first day of your last menstrual cycle? _____
5. Number of pregnancies? _____ Number of miscarriages? _____

Patient Signature: _____ **Date:** _____

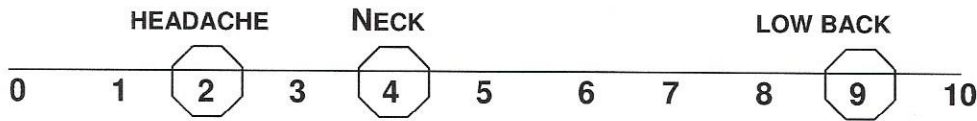
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

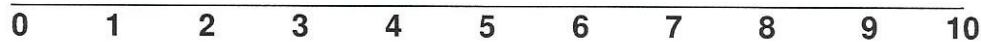
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

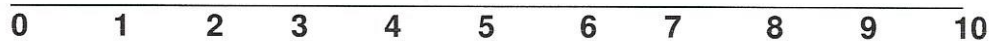
EXAMPLE:



1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

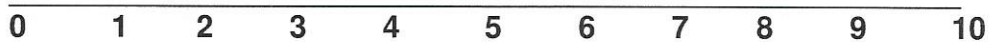


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

Systems Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the past. If neither apply, leave blank.

- _____ High Blood Pressure
- _____ Dizziness / Fainting
- _____ Insomnia
- _____ Low Resistance
- _____ Tension
- _____ Confusion
- _____ Fatigue
- _____ Ulcers
- _____ Eye/Vision Problems
- _____ Ear/Hearing Problems
- _____ Difficulty Breathing
- _____ Heart Problems
- _____ Loss of Bladder Control
- _____ Constipation
- _____ Diarrhea
- _____ Digestion Problems
- _____ Nausea
- _____ Female Problems
- _____ Prostate Problems
- _____ Diabetes
- _____ Hands / Feet Cold
- _____ Loss of Memory
- _____ Nervousness
- _____ Sweaty Palms
- _____ Speech Difficulty
- _____ Anxiety
- _____ Depression
- _____ Irritability

Anyone in your family have or had:

- ___ stroke ___ arthritis
- ___ cancer ___ hypertension
- ___ heart problems ___ diabetes

Please circle if you have any of the following:

- _____ General Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
- _____ Skin Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes
- _____ Head Trauma, headaches, dizziness, light headed
- _____ Eyes Changes in acuity photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
- _____ Nose Rhinorrhea, Epistaxis, allergies, airway obstruction
- _____ Mouth & Throat Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
- _____ Neck Stiffness, lumps / swelling / masses, pain
- _____ Lungs Cough (productive / nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
- _____ Cardiac Palpations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
- _____ Vascular Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
- _____ Breasts Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
- _____ Gastrointestinal Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, hematuria, sexually transmitted diseases, dyspareunia, scrotal swelling
- _____ Genitourinary Nocturnal polyuria, oliguria, dysuria, urgency, incontinence, urine color change
- _____ Endocrine Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation, history, pregnancy history, dysmenorrheal, premenstrual syndrome, climacteric
- _____ Hematopoietic Anemia, abdominal bleeding, lymph node enlargement,/pain
- _____ Musculoskeletal Bone/joint pain, swelling, joint deformity, trauma, restricted ROM, weakness, atrophy
- _____ Neurological Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, stasis, loss of balance, numbness, paresthesia
- _____ Psychological Mood swings, depression, anxiety, phobias

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Initial _____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Powersource Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Powersource Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. 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.

Patient's Signature: _____ Date: _____
Guardian's Signature: _____ Date: _____