

Name \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (H) \_\_\_\_\_ (O) \_\_\_\_\_  
Sex M. F. Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_  
Name of Spouse \_\_\_\_\_ Number of Children \_\_\_\_\_  
By whom where you referred to our Office \_\_\_\_\_

## HEALTH PROFILE

Reason for Today's Visit

- \_\_\_\_\_ Well Care Maintenance  
\_\_\_\_\_ Spinal Evaluation  
\_\_\_\_\_ Acute/Intensive Care

If Acute/Intensive Care, please answer questions 1 through 4 below:

1. Nature of Condition \_\_\_\_\_
2. Does this condition interfere with:  
Sleeping? Yes \_\_\_\_\_ No \_\_\_\_\_  
Working/Daily Activities? Yes \_\_\_\_\_ No \_\_\_\_\_  
Exercising? Yes \_\_\_\_\_ No \_\_\_\_\_
3. When did you first notice this condition? \_\_\_\_\_
4. Is this condition the result of  
An Auto Accident? Yes \_\_\_\_\_ No \_\_\_\_\_  
A Work Related Injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes to either, please give the date of the injury \_\_\_\_\_

Previous Chiropractic care received: (By whom and date of last visit) \_\_\_\_\_

Do you have a family physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been seen for any health condition by a doctor other than a Chiropractor  
in the last 12 month? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

List all surgeries, falls, accidents and injuries you have had and give dates:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all drugs you are taking (include all prescription and non-prescription drugs, such as  
birth control, aspirin, heart medicines, laxatives, cold tablets, etc.)

Type	Purpose
_____	_____
_____	_____
_____	_____

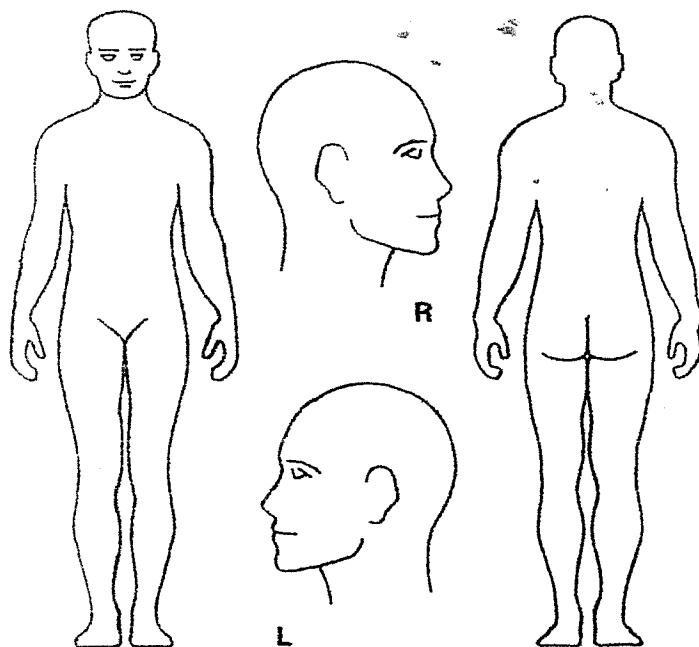
How would you describe your:

Diet	_____ Poor	_____ Good	_____ Excellent
Rest	_____ Poor	_____ Good	_____ Excellent
Exercise	_____ Poor	_____ Good	_____ Excellent
Occupational Stress (1-10, 10 being most stressful)	_____ Personal life(1-10) _____		

Name \_\_\_\_\_ Date \_\_\_\_\_

Please mark your problem area(s) with the following key:

D=Dull Pain    B=Burning    S=Stiffness    T=Tingling    N=Numbness  
X=Sharp Pain    A=Aching    R=Soreness    O=Other



On a scale of 0-10, place an X to mark the severity of your problem today.

No problem	Mild problem	Moderate problem	Severe problem	Emergency
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

Please mark the frequency of your problem.

( ) Constant    ( ) Frequent    ( ) Occasional    ( ) Rarely noticed    ( ) No problem

Please list any comments you may have about your problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your signature \_\_\_\_\_

## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Consent to evaluate and adjust a minor child:

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

### Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date