Welcome to Our Office!

Date: _____

Last _____ **First** _____ **Middle Initial** _____ **Birth Date** _____ **Age** _____

Address _____ **City** _____ **ST** _____ **Zip** _____

Phone (H) _____ **(C)** _____ **Email** _____

Occupation _____ **Employer** _____

Spouse's Name _____ **D.O.B** _____ **Spouse Ph** _____ **Employer** _____

Children's Name & Ages _____

Have you had previous Chiropractic care? yes no **Positive Experience?** yes no

Who may we thank for referring you to our office? _____ Walk In Google MD Referral Other _____

Who is your primary care physician? _____ **Phone:** _____ **Date of last physical/exam?** _____

May we update your medical doctor regarding your treatment in our office? yes no

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

Current Complaint: _____ **Date when symptom first appeared** _____

How Did it begin: _____

How often do you experience these symptoms? Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare10%

Have you ever experienced the same or similar symptoms? yes no **When?** _____

Have you been to another doctor for this problem? yes no **Who/Where?** _____

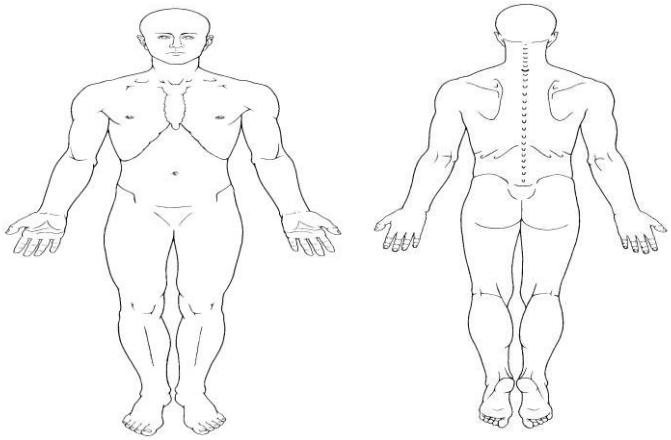
Type of Pain: Sharp Dull Ache Burn Throb Other **Do you have Numbness or Tingling?** yes no **Where?** _____

Does the Pain Radiate into: Arm Hand Leg Foot Other _____ Does not radiate

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Drugs you now take: Nerve Pills Pain Pills Muscle Relaxer Blood Pressure Other: _____

Do any family members suffer from the same complaint? If so, who? _____



Please mark off all areas of complaint on the diagrams with the following indicators:
AAA=ache DDD=dull NNN = numbness
TTT= tingling BBB= burning SSS=sharp/stabbing
XXX = other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Have you ever been in an auto accident? Past Year Past 5 Years Over 5 Years Never

Please describe: _____

Please list ALL surgeries, injuries, accidents, falls, etc: _____

List all Medications/Vitamins: _____

Do you smoke? yes no If yes, how many packs per week?_____ **Have you ever smoked in the past?** yes no **When did you quit**?_____

Do you consume alcohol? yes no If yes, how many drinks per week? _____

Do you consume caffeine? yes no If yes, how many drinks per day? _____

Do you exercise? yes no If yes, how many times per week and what type? _____

Do you have a high stress level? yes no

Stressors

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

Is there any possibility that you may be pregnant? yes no **Date of Last Menstrual Cycle** _____

Health History - Please circle all that apply

AIDS/ HIV	**Allergy Shots**	**Anemia**	**Anorexia**	**Appendicitis**	**Arthritis**	**Asthma**	**Bleeding**
Breast Lump	**Bronchitis**	**Bulimia**	**Cancer**	**Cataracts**	**Chicken pox**	**Depression**	**Diabetes**
Emphysema	**Epilepsy**	**Fractures**	**Glaucoma**	**Goiter**	**Gonorrhea**	**Gout**	**Heart dx**
Hepatitis	**Hernia**	**Herniated disc**	**Herpes**	**High Cholesterol**	**Kidney dx**	**Liver dx**	**Measles**
Migraines	**Miscarriage**	**Mono**	**M. S.**	**Mumps**	**Osteoporosis**	**Parkinson's**	**Polio**
Pacemaker	**Pneumonia**	**Prostate**	**Prosthesis**	**Implants**	**Rheumatoid**	**Stroke**	**Thyroid**
Tonsillitis	**Tuberculosis**	**Tumors**	**Typhoid**	**Ulcers**	**V. D.**	**Whooping Cough**	
Chronic Fatigue	**High Blood Pressure**		**Fibromyalgia**	**Other**_____			

Family History – List any diseases and conditions that are current health problems of family members.

_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

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, and 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 *Sermon 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 Sermon Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payers 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: _____