Date___________________________

Community Chiropractic Center

Personal History

It is a pleasure to welcome you to our family of healthy chiropractic patients here at Community Chiropractic Center. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to create better health for you and your family.

PERSONAL

Name (First, MI, Last):____ Name I prefer to use:_________________

Age:_______ Date of Birth:_____/_____/_____ S.S. #:_______________________ Gender: ☐ Female ☐ Male

Address:____ City:______________________ State:______ Zip:_________

Home Phone:_________________________ Cell Phone:______________________ Business:_____________________

Your Occupation:___________________________________ Company Name:___________________________________

Spouse's Name:_______________________________ Spouse's Date of Birth:_____/_____/_____

E-Mail:____ Who referred you to our office?___________________________

CHIEF HEALTH CONCERN

Reason for today's visit? ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

Rate your pain on the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your condition occur during: ☐ Daily Activity ☐ Auto Accident ☐ Work ☐ Other:___________________

When did your condition/accident begin? _____/_____/_____ Where did your condition occur?_____________

Please explain how your condition began: ____

____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine? ☐ No If so, how?_____________

____

Has this or something similar happened in the past? ☐ No ☐ Yes Explain:___________________________

____

If your condition is due to an accident injury, do you have an attorney? ☐ No ☐ Yes If so, what is their name? ____ Phone number? _________________________________

Using the adjacent body charts, please place an X on all affected areas.

Have you been treated by a medical physician for this pain? ☐ Yes ☐ No If so, where?

____

____

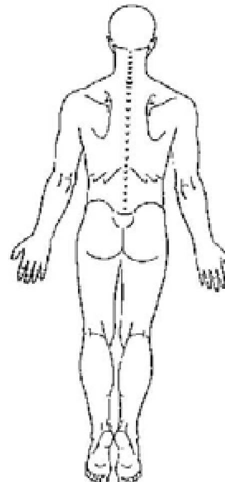
Have you ever been treated by a chiropractor? ☐ Yes ☐ No

Clinic or Dr's Name:_______________________

____

Clinic Phone #:__________________________

Left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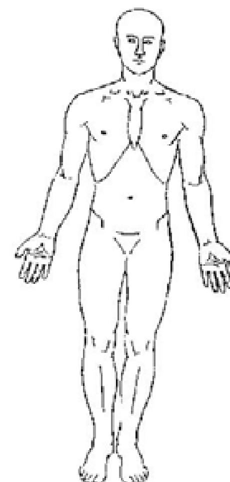
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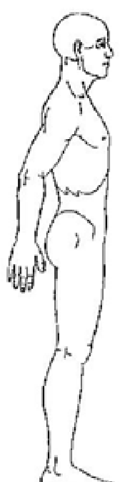
Right

HEALTH REPORT

Height:__________ Weight:__________

Are you taking supplements or vitamins? ☐ No ☐ Yes Type?____________________________________

Are you wearing: ☐ Shoe Lifts ☐ Arch Support Inserts ☐ Inner Soles

Do you exercise? ☐ No ☐ Yes _____ hours/week Are you dieting? ☐ No ☐ Yes Since ____/____/____

Do you smoke? ☐ No ☐ Yes How much? ________________ How long?__________________

Are you taking any of the following medications: ☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Insulin

☐ Muscle Relaxers ☐ Blood Thinners ☐ Tranquilizers ☐ Other______________________________

If Female, are you: Taking Birth Control? ☐ No ☐ Yes Are you nursing? ☐ No ☐ Yes

Are you Pregnant? ☐ No ☐ Yes If so, how many weeks?_______

Do you have or have you had any of the following diseases, medical conditions, or procedures?

☐ Severe/ Frequent Headaches	☐ Frequent Neck Pain	☐ Lower Back Problems
☐ Artificial Bones/ Joints/ Implants	☐ Arthritis	☐ Sinus Problems
☐ Emphysema/ Asthma	☐ Difficulty Breathing	☐ Fainting/ Seizures/ Epilepsy
☐ Stroke	☐ Heart Attack	☐ Heart Surgery/Pacemaker
☐ Heart Murmur	☐ Congenital Heart Defect	☐ Artificial Valves
☐ Mitral Valve Prolapse	☐ Rheumatic Fever	☐ Kidney Problems
☐ Ulcers/ Colitis	☐ Hepatitis	☐ Anemia/ Diabetes
☐ High/Low Blood Pressure	☐ Tuberculosis	☐ Shingles
☐ Cancer	☐ Chemotherapy	☐ Radiation

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:__________

____

____

Please list any past serious accidents with dates, including auto and slip & fall injuries:___________________

____

Please list anything that you may be allergic to:____

____

Please list any family history you think may be important for the doctor to know: ________________________

____

- We invite you to discuss with us any questions regarding our services. The best services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand my insurance company is responsible for providing any language assistance that may be required; by checking either of the following boxes, this office will inform your insurance of such requests.
  ➔ ☐ Language assistance requested ☐ Language assistance declined
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature ____ Date________________

If under 18: Parent/guardian's full name (First, MI, Last): ______________________________________

Parent/guardian's signature authorizing the treatment of minor:______________________________