

Client Name _____

Primary Care Physician _____ Phone _____

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

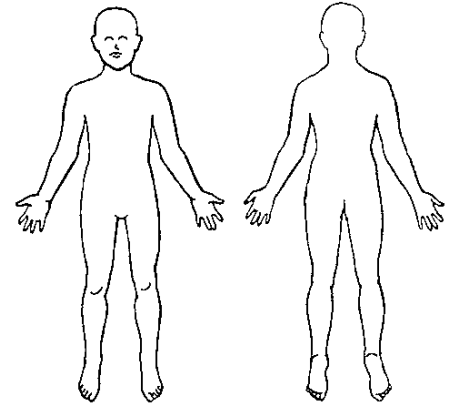
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck Pain Mid-Back Pain Low Back Pain
- Other _____

Is this problem: Work Related? Auto Related? Neither

Date Problem Began: _____ How? _____

Height _____ Weight _____



Current Complaint (how you feel today):										
0	1	2	3	4	5	6	7	8	9	10
No Symptom								Unbearable Symptom		

How often are your symptoms present?

Intermittent → 0 – 25% 26 – 50% 51 – 75% 76 – 100% → Constant

In the past week, how much has your symptom interfered with your daily activities (work, play, hobbies, etc.)?

No Interference → 0 1 2 3 4 5 6 7 8 9 10 → Significant Interference

What makes your problem better? _____

What makes your problem worse? _____

Have others attempted to solve your problem? If Yes, whom? _____

Have you had any spinal X-rays, MRI, CT Scans for your area(s) of complaint? No Yes

Date(s) Taken _____ Areas Taken? _____

Please check the following that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Recent Fever <input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Diabetes <input type="checkbox"/> Allergy _____
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Stroke (date) _____
<input type="checkbox"/> Corticosteroid Use (cortisone, prednisone)
<input type="checkbox"/> Taking Birth Control Pills
<input type="checkbox"/> Dizziness / Fainting
<input type="checkbox"/> Numbness in Groin / Buttocks
<input type="checkbox"/> Cancer / Tumor (explain) _____

<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Other Health Problems (explain) _____

 | <input type="checkbox"/> Digestion Problems <input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Mood Swings / Irritability
<input type="checkbox"/> Addiction(s) _____
<input type="checkbox"/> Currently Pregnant, # weeks _____
<input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/> Significant Morning Pain and/or Joint Stiffness
<input type="checkbox"/> Pain Unrelieved by Position or Rest
<input type="checkbox"/> Pain at Night
<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Surgeries / Hospitalizations _____

<input type="checkbox"/> Medications and/or Nutritional Supplements _____

 | |
|---|--|--|

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems / Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. I understand that I am responsible for all charges for services rendered to me and I agree to notify the doctor immediately if I have changes in my health condition, insurance coverage or contact information. I understand that the doctor may need to contact my primary care physician and I therefore, I give authorization to my chiropractor and staff to contact my physician, if necessary.

Patient Signature _____

Date _____

Stresses that affect the nervous system may be PHYSICAL, CHEMICAL or EMOTIONAL in nature. Understanding the stresses that have acted upon you assists in me serving you. With each of the following questions, please check only the boxes that apply. Leave blank anything that does not apply to you.

PHYSICAL STRESS HISTORY

- Falls from Crib/stroller Falls down stairs Falls on playground Falls during sports
 Falls during recreation Knocked unconscious Extensive dental work Orthodontia / braces
 Broken bones _____

- Military service Military combat Physical fights Physical abuse Involved in Sports
 Automobile accidents _____

Accidents: Motorcycles Bus Train Bicycle Airplane Other _____

- Daily Activities: Sitting Standing Walking Desk work Phone Work Computer Work
 Sports Exercise Watch TV Driving Traveling Manual labor Bending/Lifting
 Read prolonged periods Wear contact lenses Wear glasses Wear bifocals
 Hospitalizations _____
 Surgeries _____

Did your mother have a difficult pregnancy with you? Yes No

Did your mother have any falls, accidents or physical injuries during pregnancy? Yes No

- Was your birth: Drug induced Forceps or Suction Prolonged "C" Section
 Cord around the neck Breech Natural
 Other: _____

My birth was: At Home In a Birthing Center In a Hospital Other _____

- Have you ever had: Spinal Tap Spinal Injections Physical Therapy Neck Collar
 Spinal Brace Traction X-Ray Treatments Heel Lifts Corrective Shoes
 Extensive Diagnostic X-Rays Acupuncture Chemotherapy Transfusion

How do you grade your current physical health? Excellent Good Fair Poor

Is your physical health Getting Better Not Changing Getting Worse

CHEMICAL STRESS HISTORY

- Prescription Drugs _____
 Non-Prescription Drugs _____
 Recreational Drugs _____
 Supplements _____

Have you ever worked with chemicals fumes dust powders smoke

Was your mother taking any drugs immediately prior to, or during her pregnancy with you? Yes No

Did your mother Drink alcohol Smoke Other: _____ while pregnant with you?

Do you consume: Alcohol Coffee Tobacco Artificial sweeteners

Refined sugar Soda Tap water Fast Food

Do you have problems with Alcohol Abuse Drug Abuse Overeating

Do you follow any special diets? No Yes _____

EMOTIONAL STRESS HISTORY

STRESS / TENSION SOURCES	PAST STRESS LEVEL	CURRENT STRESS LEVEL
Childhood Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
School Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Recreational Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Family Relationship Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Parent's Divorce / Separation	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Personal Relationship Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Your Divorce / Separation	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Work Related Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Financial Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Commuting Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress from Change in Job / Work	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress from Change in Lifestyle	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress from Loss of Loved One	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress from Being Sick	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Abuse (Verbal, Physical, Emotional, Sexual)	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress from Moving / Relocation	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme

Were you incubated or isolated after birth? Yes No Were you: Bottle Fed Nursed Both

Have you pursued other avenues toward growth, healing and personal development?

Do you have any addiction or compulsions? No Yes _____

How do you grade your emotional & mental health? Excellent Good Fair Poor

Is your emotional & mental health Getting Better Not Changing Getting Worse

Choose the one statement below that best represents how you feel about your current situation.

- I feel helpless; nothing works.
- I don't like what I am feeling, and I hope you can fix it.
- I feel this is a pattern that has happened to me before; it is back again.
- I feel there is a message my body is giving me.
- I am looking for assistance in becoming healthier so I can move past my health concern.
- I realize my condition may be a necessary experience in getting to the real problem.
- I don't know how I feel. I am too preoccupied with my present condition.
- I am looking for something to help me enhance my quality of life and further enhance my wellness.

Is there anything else you may wish to share which may help to better understand you, your history, or your needs which have not been discussed in this profile? (If necessary, please use the back of this form)

What would motivate you to tell others about the care you receive in this office and encourage others to get under Network Care?

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for the services rendered. If my insurance requires a referral and I receive care without proper authorization, I understand I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of my benefits and to authorize the use of this signature on all insurance submissions.

A copy of this document shall be considered as valid as the original.

Client or Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that my doctor acts in strict accordance with federal privacy regulations (HIPAA) and that I may request my own copy of the doctor's Notice of Privacy Practices for Protected Health Information at any time.

Client or Guardian Signature

Date

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I request and consent to the performance of physical examination and treatment on me or the patient named below for whom I am responsible by any licensed doctors or authorized providers in the office. I acknowledge that chiropractic care has potential (although extremely unlikely) complications including but not limited to fracture, dislocation, stroke, sprains and strains and muscular discomfort. I do not expect the doctor to anticipate all potential risks or complications and I wish to rely on the doctor to exercise clinical judgment in my best interest during the entire course of my care, based on the facts known at that time. I understand that I may speak to the doctor and ask questions about potential risks or any other concerns I may have at any time, including before I sign this acknowledgement and receive any physical examinations or treatments.

Print Patient Name

Patient or Guardian Signature

Date