

Patient Information

Full Name: _____

Date of Birth: ___ / ___ / _____ Age: _____

Gender: Male Female Other

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ You may leave a voicemail and/or send text reminders to this number
Email: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Insurance Information (if applicable)

Insurance Company: _____

Policy # / Member ID: _____ Group #: _____

Primary Policy Holder: _____ DOB of Policy Holder: ___ / ___ / _____

Reason for Visit

Main complaint / symptoms: _____

When did this begin? _____

Was it caused by: Accident Gradual onset Other: _____

Rate your pain: 0 (no pain) – 10 (worst pain) → 0 1 2 3 4 5 6 7 8 9 10

Describe the pain: Sharp Dull Throbbing Burning Shooting

Other: _____

What makes it better? _____

What makes it worse? _____

Health History

Have you had chiropractic care before? No Yes -If so, who? _____



List surgeries or major illnesses: _____

Current medications/supplements: _____

Allergies: _____

Do you have or have you ever had (check all that apply):

- Headaches/Migraines Neck Pain Back Pain Arthritis Heart Disease
 Diabetes Osteoporosis Cancer Numbness/Tingling High Blood Pressure
 Asthma Other: _____

Lifestyle

Exercise: Daily Weekly Rarely Never Tobacco Use: Yes No

Alcohol Use: Yes No Caffeine: Yes No — If yes, how much? _____

Sleep: Average hours per night: _____ Stress Level: Low Moderate High

Authorization & Signature

I certify that the above information is true to the best of my knowledge. I authorize the release of any medical information necessary to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: _____ Date: ____ / ____ / ____

HIPAA Privacy Acknowledgement

I understand that this office follows all applicable privacy laws to protect my health information. I acknowledge that I have been informed of my right to review the full Privacy Practices policy (HIPPA Notice) and that a copy is available upon request.

Patient Signature: _____ Date: ____ / ____ / ____

Consent to Treat

I hereby request and consent to chiropractic evaluation and treatment by the doctors of this clinic and their staff. I understand that the practice of chiropractic, like all forms of health care, carries some risks, including but not limited to soreness, muscle strain, and in rare cases, more serious complications. I have had the opportunity to discuss these risks and have all my questions answered.

Patient Signature: _____ Date: ____ / ____ / ____