

## PERSONAL INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Mobile Phone: \_\_\_\_\_ Pager: \_\_\_\_\_ Email: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
 Marital Status:  S  M  D  W Spouses Name: \_\_\_\_\_ # of Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 How were you referred to our office?:  Yellow Pages  Drive By  Internet  TV  
 Friend \_\_\_\_\_  Other \_\_\_\_\_  
 Do you Have a Primary Care Physician?  Yes  No Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Have you ever seen a Chiropractor Before?  Yes  No If Yes, When: \_\_\_\_\_  
 Where: \_\_\_\_\_ Results: \_\_\_\_\_

## MAJOR COMPLAINT INFORMATION

Complaint #1	Type of Pain:	Worse with which of these activities:	Result of:
_____ _____ Began?: _____ Have you had this in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it Getting Worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant	<input type="checkbox"/> Aching <input type="checkbox"/> Tight <input type="checkbox"/> Burning <input type="checkbox"/> Stiff <input type="checkbox"/> Deep <input type="checkbox"/> Tender <input type="checkbox"/> Dull <input type="checkbox"/> Tingling <input type="checkbox"/> Numb <input type="checkbox"/> Throbbing <input type="checkbox"/> Sharp/ <input type="checkbox"/> Shooting Stabbing <input type="checkbox"/> Sore	<input type="checkbox"/> Lying on back <input type="checkbox"/> Stooping <input type="checkbox"/> Lying on side <input type="checkbox"/> Bending <input type="checkbox"/> Lying on stomach <input type="checkbox"/> Twisting/Turning <input type="checkbox"/> Turning over <input type="checkbox"/> Sitting <input type="checkbox"/> Getting in/out of car <input type="checkbox"/> Standing <input type="checkbox"/> Dressing self <input type="checkbox"/> Walking <input type="checkbox"/> Pushing <input type="checkbox"/> Climbing <input type="checkbox"/> Pulling <input type="checkbox"/> Sneezing <input type="checkbox"/> Lifting <input type="checkbox"/> Coughing <input type="checkbox"/> Reaching <input type="checkbox"/> Other: _____	<input type="checkbox"/> Auto Accident <input type="checkbox"/> Work Injury <input type="checkbox"/> Other: _____ _____
_____ _____ Began?: _____ Have you had this in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it Getting Worse?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant	<input type="checkbox"/> Aching <input type="checkbox"/> Tight <input type="checkbox"/> Burning <input type="checkbox"/> Stiff <input type="checkbox"/> Deep <input type="checkbox"/> Tender <input type="checkbox"/> Dull <input type="checkbox"/> Tingling <input type="checkbox"/> Numb <input type="checkbox"/> Throbbing <input type="checkbox"/> Sharp/ <input type="checkbox"/> Shooting Stabbing <input type="checkbox"/> Sore	<input type="checkbox"/> Lying on back <input type="checkbox"/> Stooping <input type="checkbox"/> Lying on side <input type="checkbox"/> Bending <input type="checkbox"/> Lying on stomach <input type="checkbox"/> Twisting/Turning <input type="checkbox"/> Turning over <input type="checkbox"/> Sitting <input type="checkbox"/> Getting in/out of car <input type="checkbox"/> Standing <input type="checkbox"/> Dressing self <input type="checkbox"/> Walking <input type="checkbox"/> Pushing <input type="checkbox"/> Climbing <input type="checkbox"/> Pulling <input type="checkbox"/> Sneezing <input type="checkbox"/> Lifting <input type="checkbox"/> Coughing <input type="checkbox"/> Reaching <input type="checkbox"/> Other: _____	<input type="checkbox"/> Auto Accident <input type="checkbox"/> Work Injury <input type="checkbox"/> Other: _____ _____
_____ _____ Began?: _____ Have you had this in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it Getting Worse?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant	<input type="checkbox"/> Aching <input type="checkbox"/> Tight <input type="checkbox"/> Burning <input type="checkbox"/> Stiff <input type="checkbox"/> Deep <input type="checkbox"/> Tender <input type="checkbox"/> Dull <input type="checkbox"/> Tingling <input type="checkbox"/> Numb <input type="checkbox"/> Throbbing <input type="checkbox"/> Sharp/ <input type="checkbox"/> Shooting Stabbing <input type="checkbox"/> Sore	<input type="checkbox"/> Lying on back <input type="checkbox"/> Stooping <input type="checkbox"/> Lying on side <input type="checkbox"/> Bending <input type="checkbox"/> Lying on stomach <input type="checkbox"/> Twisting/Turning <input type="checkbox"/> Turning over <input type="checkbox"/> Sitting <input type="checkbox"/> Getting in/out of car <input type="checkbox"/> Standing <input type="checkbox"/> Dressing self <input type="checkbox"/> Walking <input type="checkbox"/> Pushing <input type="checkbox"/> Climbing <input type="checkbox"/> Pulling <input type="checkbox"/> Sneezing <input type="checkbox"/> Lifting <input type="checkbox"/> Coughing <input type="checkbox"/> Reaching <input type="checkbox"/> Other: _____	<input type="checkbox"/> Auto Accident <input type="checkbox"/> Work Injury <input type="checkbox"/> Other: _____ _____



## CHECK THE FOLLOWING CONDITIONS AS THEY APPLY TO YOU

Never	Previously	Presently		Never	Previously	Presently		Never	Previously	Presently		Never	Previously	Presently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENERAL SYMPTOMS/CONDITIONS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTRO-INTESTINAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>EYE/EAR/NOSE/THROAT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>RESPIRATORY</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy (what) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills (Constant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Discharge	<b>GENTO-URINARY</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Noises				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to Control Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Pain in arms/legs/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<b>NEUROLOGICAL</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<b>CARDIO-VASCULAR</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobias
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss or Impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Tail Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Curvature	<b>FOR FEMALES ONLY</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Disc Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Pregnant at this time?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ other												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ other												

### ADDITIONAL INFORMATION

List all medications you are taking now, including over the counter medication: \_\_\_\_\_

Do you have, or have you ever had, any diseases or medical problems not listed?  Yes  No

If so, please list: \_\_\_\_\_

Any additional information you would like the doctor to know about before beginning care at Total Health

Chiropractic Center? \_\_\_\_\_

## FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Total Health Chiropractic Center. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Total Health Chiropractic Center responsible for any errors or omissions that I may have made in the completion of this form

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Total Health Chiropractic Center to treat my condition as deemed appropriate.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## RECORDS RELEASE

To \_\_\_\_\_, I hereby authorize you to release to \_\_\_\_\_ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of \_\_\_\_\_ to \_\_\_\_\_.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Staff: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. \_\_\_\_\_ and whomever he may designate as assistance to administer chiropractic care as he deems necessary to my \_\_\_\_\_ (indicate relationship to child).

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Signature of Staff: \_\_\_\_\_ Date: \_\_\_\_\_