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*Please allow our staff to make a copy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.*

Today's Date (MM/DD/YYYY) \_\_\_\_\_ How did you hear about our office? Yellow Pages Google Drive by Event

Whom may we thank for referring you? \_\_\_\_\_

## PERSONAL

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle(or Initial) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email Address \_\_\_\_\_

Gender  Male  Female Birth Date (MM/DD/YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed  Separated Spouse's Name \_\_\_\_\_

Other Family Members \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Preferred method of contact  Home Phone  Cell Phone  Work Phone  Email

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

## INSURANCE

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_ Carried by  Self  Spouse  Parent

Insured's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial) \_\_\_\_\_

Insured's Birth Date (MM/DD/YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

## PREVIOUS CHIROPRACTIC CARE

Have you seen a Chiropractic Physician before? \_\_\_ Yes \_\_\_ No

Who? \_\_\_\_\_ When? \_\_\_\_\_

Reason for Visit at that time: \_\_\_\_\_

How did you respond? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The symptom(s) that have prompted me to seek care include: \_\_\_\_\_

And are the result of:  Work Injury  Auto Accident  Other \_\_\_\_\_

Onset: When did your symptoms begin \_\_\_\_\_

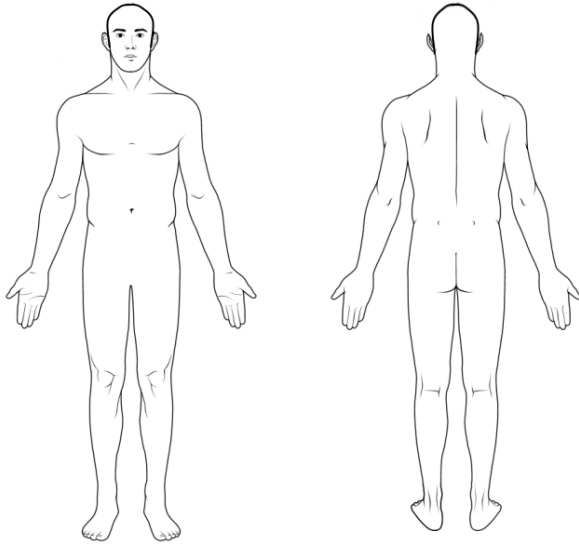
Intensity: How much pain does it cause? 0 1 2 3 4 5 6 7 8 9 10 Intensity: How much pain does it cause? 0 1 2 3 4 5 6 7 8 9 10  
 Area of Complaint #1 \_\_\_\_\_ Area of Complaint #2 \_\_\_\_\_

Duration and timing: How often do you feel your symptoms?  Constant  Comes and goes How often? \_\_\_\_\_

Symptoms: What does it feel like? Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting  
 Throbbing Stabbing Other: \_\_\_\_\_

**Location: Were does it hurt? Circle area(s) on the illustration.**  
**X** for current condition, **O** for conditions experienced in the past.

What areas, if any, does the pain radiate, shoot or travel?  
 \_\_\_\_\_



Aggravating/relieving factors: What makes it better or worse,  
 time of day, movements, certain activities, etc.?

What makes the pain **worse**?  
 \_\_\_\_\_

What makes the pain **better**?  
 \_\_\_\_\_

What previous treatments have you done for this condition?  
 \_\_\_\_\_  
 \_\_\_\_\_

What else should the Doctor know about your current condition?  
 \_\_\_\_\_

Activity	Pain	No	Mild	Moderate	Severe	Activity	Pain	No	Mild	Moderate	Severe
Sitting		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery Shopping		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Light Lifting		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching Overhead		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering/bathing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing self		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting out of car		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving car		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercise		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard Work		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Intimacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Family History:**

Relative	State of Health	Age	Illnesses	Age at death	Cause of death
	Good Poor				
Mother	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____
Father	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____
Sister 1	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____
Sister 2	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____
Brother 1	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____
Brother 2	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____
_____	<input type="radio"/> <input type="radio"/>	_____	_____	_____	_____

Are there any other hereditary health issues of which you are aware? \_\_\_\_\_ 2

**MEDICAL HISTORY**

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Tumor
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Other _____

**For Females Only:**      Birth Control Pills      Hormonal Replacement      Pregnancy

List all prescription medications you are currently taking \_\_\_\_\_

List all the over-the-counter medications you are currently taking \_\_\_\_\_

List all Supplements and Herbs \_\_\_\_\_

List all surgical procedures you have had \_\_\_\_\_

**Social History:**

Alcohol Use	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasional	How much? _____	Mercury Filling	Yes No
Coffee Use	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasional	How much? _____	Recreational Drugs	Yes No
Tobacco Use	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasional	How much? _____		
Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasional	How much? _____		
Pain Relievers	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasional	How much? _____		
Water Intake	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasional	How much? _____		
Hobbies:	_____			

**Daily Living:**

How much sleep are you getting per night? \_\_\_\_\_ Hours      Preferred Sleeping Position:  Back  Side  Stomach

In addition to the main reason for your visit, what are your other health goals? \_\_\_\_\_

**ACKNOWLEDGEMENTS**

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and initial your agreement.

\_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered at Health Loft Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

\_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am no pregnant. Date of last menstrual period (MM/DD/YYYY) \_\_\_\_\_

\_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

\_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services that I receive.

\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

**Patient Health Information Consent Form**

We Want you to know how your health information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. Patient understand and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, health care operations, and coordination of care.
2. The Patient has the right to examine and obtain a copy of his or her own health records at any time request corrections. The Patient may request to know what disclosure have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in the office.
4. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations the chiropractic physician has the right to refuse to give care.
5. I understand that upon entering this facility my name will be signed on a sign-in sheet that will remain in the reception area of the office. I also realize that any person entering this office may read my name on the sign-in sheet as a patient.

I have read and understand how my patient health information will be used and i agree to these policies and procedures.

**Consent For Treatment Of Minor Child**

I give permission to Donay Life and Wellness Center to administer chiropractic care as deemed necessary to my child.

Patient Name: \_\_\_\_\_

Patient Parent or Legal Guardian Signature: \_\_\_\_\_

