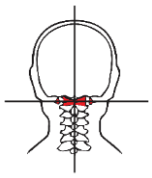


CHIROPRACTIC INTEGRATION

For Office Use Only

Date _____

Pt. ID_____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____. __ Morn. __ Day. __ Night.

Personal E-mail – Address _____. Professional E-Mail Address _____.

Occupation _____ Employer_____.

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner

_____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

What concerns do you feel our doctors can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason:

_____

_____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

If you have recently delivered a child, how long ago? _____ Where? _____

Health, Wellness and Chiropractic Care

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

****Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.**

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present.
Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

How many bowel movements do you have in a day? _____

How much water do you consume per day? _____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall sleep quality? # of hours/night_____❑ Good ❑ Fair ❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

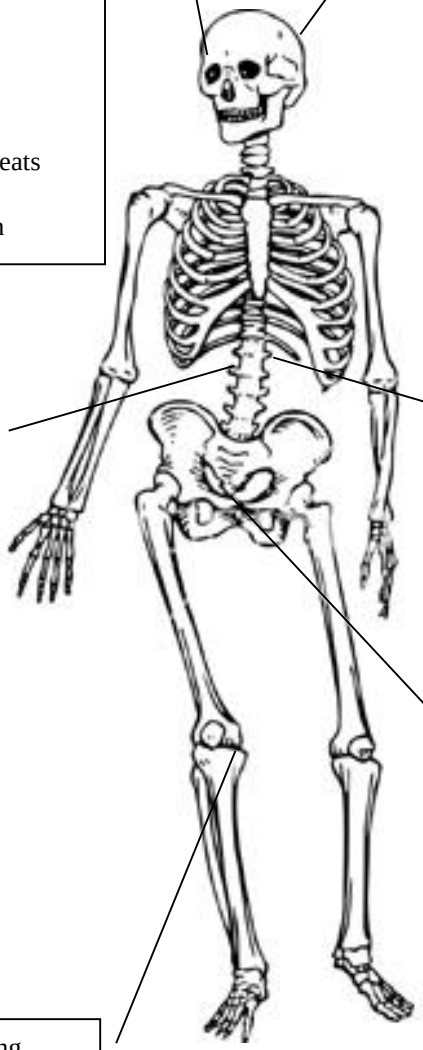
❒ OTHER_____.

Personal Health History

Please check any box that applies to your health history previously or currently.

- Anxiety
- Fainting
- Lower Neck Pain
- Shoulder Pain
- Asthma/ Difficulty Breathing
- Seasonal Allergies
- Frequent Colds
- Pneumonia
- Torticollis
- Thyroid Dysfunction
- Fever/ Chills/ Cold Sweats
- Easily Bruised
- Abnormal Hair Growth

- Pain at Base of the Skull
- Migraines/Headaches
- Memory Loss
- Sensitivity to Light
- Vertigo/Dizziness
- Tinnitus/ Ringing In Ears
- Glasses/Double Vision
- Numbness/Tingling
- Facial Pain
- Swollen Glands
- Tooth Decay/ Bleeding Gums
- Cold Sores and Acne
- Frequent Sneezing or Discharge
- Loss of Sleep



- Fatigue
- Skin Rash/ Eczema
- Pain between Shoulders
- Food Sensitivities/ Allergies
- Indigestion
- Gas/ Bloating
- Diarrhea / IBS / Constipation
- Liver Disease
- Pancreatitis
- Kidney/ Gall Stones
- Lyme
- Unexplained Weight gain/loss
- Carpal Tunnel
- Tennis/ Golfers Elbow

- High Blood Pressure
- Heart Arrhythmia
- Chest Pain
- Heart Burn/ Reflux/ GERD
- Ulcers
- Vomiting
- Anemia
- Lower Back/ Hip Pain

Female:

- Abnormal Menses/ PMS
- Age of First Menses _____
- Number of Pregnancy's ____
- Birth Control
- Frequent UTI
- Yeast Infection
- Decreased Sex Drive

Male:

- Erectile Dysfunction
- Frequent UTI
- Testicular Pain/ Swelling
- Hemorrhoids
- Prostate Issues

- Knee Pain/ Popping/ Grinding
- Varicose Veins
- Fluid in Legs/Edema
- Sciatic Pain
- Frequent Ankle Sprain
- Heel Lift/ Foot Orthotics
- Decreased Coordination/ Balance

FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

Da 1, 2, and 3 Visit Fees: Comprehensive Exam, Consultation, and Report of Findings:

Single: $ 180.00 . Couple: $ 300.00 . Additional Family $ + 100.00 . # _____.

PLEASE READ AND SIGN

1. I acknowledge that some of the services offered by Chiropractic Integration may not be covered by insurance and I am responsible for all fees incurred during office visits.
2. I have been informed that a copy of Chiropractic Integration's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the office.
3. I consent to receive communication from Chiropractic Integration via email, postal mail, text and telephone messaging in connection with my care.
4. I agree to follow doctor's recommendations to the absolute best of my ability to ensure that I get the absolute best results.
5. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

I give the doctors at Chiropractic Integration permission to examine and render care. This initial visit includes a health history consultation, chiropractic exam and evaluation, neurological exam via infrared thermography, x-rays and any initial care that is determined to be clinically necessary and mutually agreed upon.

Patient Name (Printed) _____.

Signature _____. Date: _____.

Signature of Parent or Legal Guardian if Minor_____Date: _____.

Accompanying Adult* Signature: _____. Date _____.

Thank you for choosing Chiropractic Integration.
We look forward to working with you and your family.