ADJUST TO HEALTH CHIROPRACTIC, INC.

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Please fill out the following forms, in print and with as much detail as possible. Thank you!

Name ____ Date ____________
Address _____________________________ City ____________ State _______ Zip _________
Home Phone _______________ E-mail ______________________ Date of Birth ____________
Age ________ Sex (M) (F) Referred by ___________________________ (or how you found us)
Social Security Number ___________________ Driver's License Number _________________
Employer ____________________ Occupation ____________ Office Phone _______________

Name of Spouse ___________________________ Married__ S__ W__ D__ Children_________

Have you ever had chiropractic care before? Yes __No __ For what problem? _____________
When was your last adjustment? _____________ Were the results satisfactory? Yes __No __

Major complaints and symptoms – **Please be specific:** ________________________________
____
____
How do you believe your problem/pain began? ______________________________________
____
When did you first notice this problem/pain? ______________________________________
____

Have you ever had this condition before or a similar condition? _______ When? __________
Have you lost any work? _____________ If so, date you last worked ____________________

What positions or activities aggravate your condition? ________________________________

What positions or activities relieve your condition? __________________________________

Have you ever been treated by a Medical Physician for this ailment? Yes __ No __
Describe the type of treatment ____
Family physician's name ____

Will your care be covered by any insurance company? Yes ___ No ___

Automobile ___ Workers' Compensation ___ Aetna ___ Blue Cross/Blue Shield ___ Cigna ___

UnitedHealthcare ___Medicare ___ AARP ___ AHCCCS ___ Other _______________________

Have you had any accidents, such as auto, fall down stairs or from ladder, etc. (even as a child)? Yes __No __ If so, when? ____

Are you aware of any allergies to anything? ____

2Name ______________________________________ Date _________________

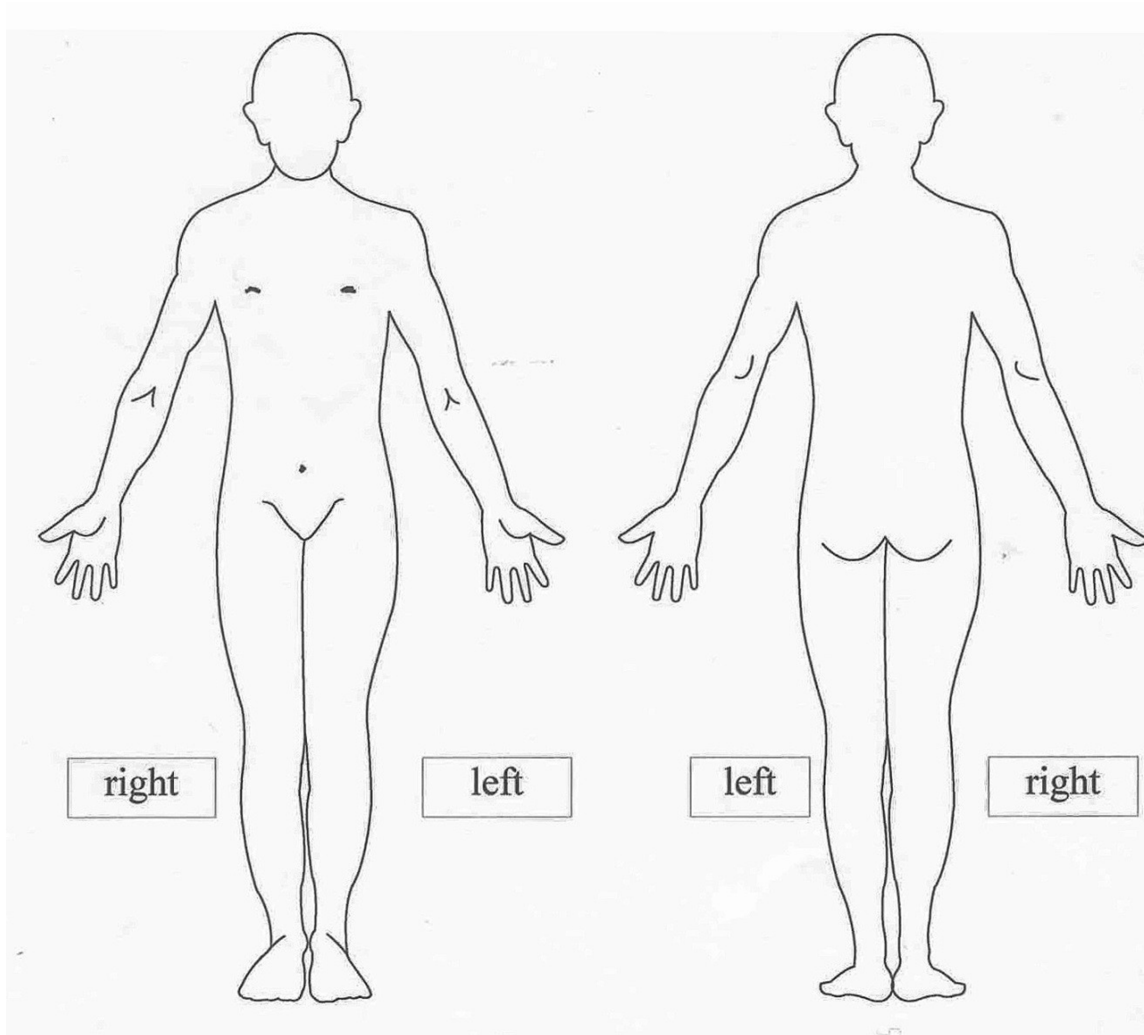
Show Area of Pain or Unusual Sensation/Feeling:

Mark the areas of this body where you feel the described sensations.

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

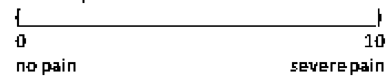
Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////

Pain Chart



Please mark on the pain scale from Zero to 10 the pain you feel from your condition.

(10 being the worst pain you have felt with this condition.)



3Name ______________________________________ Date _________________

What prescriptions are you taking, if any? ____
____

Any vitamins or herbs? ____

Have you broken/fractured any bones? ____

What operations have you had and when? ____
____

Have you had any cosmetic surgery, breast implants, etc.? Yes __No __ Year _____________

Give dates you have had any of the following (if exact care is unknown, give approximate).

Blood tests ___________________________

Urinalysis ____________________________

MRI _________________________________

CT Scan ______________________________

Ultrasound ___________________________

Radiation Treatment __________________

X-Ray examination ____________________

Other special treatment _______________

____

____

Have you been treated for **any** health condition by a physician in the past year? ___________

If yes, what condition? ____

Have you lost or gained significant weight (greater than 15 lbs.) in the past year? Yes __No __

Use this space for any additional information you may wish to discuss ___________________
____
____

Per changes in documentation based on the Affordable Care Act, please answer the following:

Height __________Weight __________

Blood Pressure _____________________ (We will determine)

Race _______________________

Ethnicity ______________________

For women:

Date of last menstrual period _________________________

Do you have any reason to believe that you may be pregnant? Yes___ No___

4Name ______________________________________ Date _________________

Do you have vertigo (dizziness)? Yes ___ No ___
Do you pass out easily (faint or loss of consciouness)? Yes ___ No ___
Have you lost sight in one eye? Yes ___ No ___
Do you have slurred speech or difficulty with speech? Yes ___ No ___
Do you have indigestion or difficulty swallowing? Yes ___ No ___
Do you have any difficulty with walking, with coordination or falling to one side? Yes __ No __
Do you have nausea or vomiting? Yes ___ No ___
Do you have numbness on one side of your face or body? Yes ___ No ___
Do you have or have you ever had difficulty in arranging words properly? Yes ___ No ___
Do you have a headache or head pain that is unlike any you have had before? Yes ___ No ___
Do you have headaches for hours or days? Yes ___ No ___
Do you have chest pain? Yes ___ No ___
Do you have any change in bowel or bladder habits? Yes ___ No ___
Do you have a sore that does not heal? Yes ___ No ___
Do you have any unusual bleeding or discharge? Yes ___ No ___
Do you have any thickening in your breasts or elsewhere? Yes ___ No ___
Do you have a change in any wart or mole? Yes ___ No ___
Do you have a nagging cough or hoarseness? Yes ___ No ___
Do you have night sweats? Yes ___ No ___
Do you have pain in your neck, jaw, or face? Yes ___ No ___
Do you have drooping eyelid or change in your pupils? Yes ___ No ___
Do you have ringing in your ears? Yes ___ No ___
Have you ever had cancer? Yes ___ No ___
Does your pain ever wake you from a sound sleep? Yes ___ No ___
Are you losing weight now without trying? Yes ___ No ___
Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___
Have you had any loss of bladder or bowel control? Yes ___ No ___
Have you lost consciousness or had double vision recently? Yes ___ No ___

Social History

SMOKER ___ Yes or ___ No, if Yes, how many packs ___________
ALCOHOL ___ Yes or ___ No, if Yes, how much ___________

Family History

Did your mother or father have any of the following? Use **M** for mother, **F** for Father, **B** for both

[ ] High Blood Pressure
[ ] Heart Attack
[ ] Emphysema
[ ] Seizure-Convulsions
[ ] HIV Positive
[ ] Asthma
[ ] Diabetes
[ ] Kidney Disease
[ ] Ulcer or Stomach Problems
[ ] Stroke (Please indicate age when stroke occurred, Mother ___ Father ___)
[ ] Arthritis-Rheumatism
[ ] Mental Illness
[ ] Thyroid Disease
[ ] Circulation Problems
[ ] Cancer

Signature: ____