About the Patient

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____)_____

Cell Phone (_____)_____

Marital Status ❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed

How did you hear about our office? _____

Birth Date _____

Gender ❒ Male ❒ Female # of children _____

Employer _____

Work Phone (_____)_____

Type of Work _____

Social Security # _____

Email Address _____

Reason for This Visit

What is your chief complaint for this visit _____

_____

How long has this persisted _____

Have you seen other doctors for this condition? _____

Dr.'s Name (s) _____

Type of Treatment _____

Results _____

Is the purpose of this appointment related to:

❒ Job ❒ Sports ❒ Auto ❒ Fall

❒ Chronic Discomfort ❒ Home Injury ❒ Other

Please explain _____

If job related, have you made a report of your accident to your employer? ❒ Yes ❒ No

Has this condition occurred before ❒ Yes ❒ No

Symptomatology:

1. The pain is located _____ When did this condition begin_____

Has this condition ❒ Gotten Worse ❒ Stayed Consistent ❒ Intermittent ❒ _____ ❒ _____

The pain is made better by ❒ massage ❒ sitting ❒ standing ❒ nothing ❒ _____ ❒ _____

Does this condition interfere with ❒ work ❒ sleep ❒ daily routine ❒ _____ ❒ _____

How would you describe the pain: ❒ dull ❒ sharp ❒ aching ❒ _____ ❒ _____

Is there radiation into ❒ shoulder R L ❒ hand(s) R L ❒ leg(s) R L ❒ foot R L ❒ _____ ❒ _____

[ ] There is [ ] There is not parasthesia (tingling/numbness) into: _____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

2. The pain is located _____ When did this condition begin_____

Has this condition ❒Gotten Worse ❒Stayed Consistent ❒Intermittent ❒ _____ ❒ _____

The pain is made better by ❒ massage ❒ sitting ❒ standing ❒ nothing ❒ _____ ❒ _____

Does this condition interfere with ❒ work ❒ sleep ❒ daily routine ❒ _____ ❒ _____

How would you describe the pain: ❒ dull ❒ sharp ❒ aching ❒ _____ ❒ _____

[ ] There is [ ] There is not radiation into _____

[ ] There is [ ] There is not parasthesia (tingling/numbness) into:_____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Please mark X for present conditions, O for past conditions

Please check each of these diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect overall diagnosis, care plan and the possibility of being accepted for care.

- ❒ Fractured Bones
- ❒ Auto Accidents
- ❒ Other Accidents/Falls
- ❒ Back Curvature
- ❒ Arthritis
- ❒ Diabetes
- ❒ Swollen/Painful Joints
- ❒ Convulsions/Epilepsy
- ❒ Skin Problems
- ❒ Cancer
- ❒ Chemotherapy
- ❒ Frequent Colds/Flu
- ❒ Depressed
- ❒ Irritable
- ❒ Anemia
- ❒ Tremors
- ❒ Alcohol/Drug Abuse
- ❒ Allergies
- ❒ Sinus Problems
- ❒ Eating Disorders
- ❒ Trouble Sleeping
- ❒ Trouble Concentrating
- ❒ Learning Disability
- ❒ Mood Changes
- ❒ Headache
- ❒ Pain/Stiff Neck R or L
- ❒ Numbness/Tingling/Pain Arms/Hands/Fingers R or L
- ❒ Jaw Pain/TMJ R or L
- ❒ Head/Shoulders Feel Tired
- ❒ Shoulder Pain R or L
- ❒ Dizziness
- ❒ Ear Infection
- ❒ Ringing in Ears R or L
- ❒ Hearing Loss R or L
- ❒ Fainting
- ❒ Blurred/Double Vision
- ❒ Upper Back Pain/Stiffness
- ❒ Mid Back Pain/Stiffness
- ❒ Low Back Pain/Stiffness
- ❒ Numbness, Tingling or Pain in buttocks, thighs, legs, feet toes
- ❒ Pain with cough, sneeze
- ❒ Hip Pain R or L
- ❒ Foot Trouble R or L
- ❒ Chest Pain
- ❒ Asthma
- ❒ Lung Problems
- ❒ Difficulty Breathing
- ❒ Heart Problem
- ❒ Bed Wetting
- ❒ Pacemaker
- ❒ Stroke
- ❒ High/Low Blood Pressure
- ❒ Varicose Veins
- ❒ Thyroid Problems
- ❒ Liver Trouble
- ❒ Gall Bladder Trouble
- ❒ Digestive Problems
- ❒ Heartburn
- ❒ Ulcers/Colitis
- ❒ Diarrhea/Constipation
- ❒ Colon Trouble
- ❒ Hemorrhoids
- ❒ Prostate Problems
- ❒ Impotence
- ❒ Kidney Trouble
- ❒ AIDS/HIV
- ❒ Hepatitis (A, B, C)

FOR WOMEN ONLY

Are you pregnant? ❒ Yes ❒ No

Are you nursing? ❒ Yes ❒ No

Are you taking birth control? ❒ Yes ❒ No

Do you experience painful periods? ❒ Yes ❒ No

Do you have irregular cycles? ❒ Yes ❒ No

- ❒ Menstrual Problems/PMS
- ❒ Menopausal Problems

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for their correction of whatever is malfunctioning in their bodies.

Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❒ **Relief Care:** Symptomatic relief of pain or discomfort.
- ❒ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- ❒ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.
- ❒ I want the doctor to select the type of care appropriate for my condition.

_____

Patient's Signature Date

Medication I Now Take

- ❒ Nerve Pills _____
- ❒ Pain Killers _____
- ❒ Muscle Relaxers _____
- ❒ Blood Pressure Medication _____
- ❒ Blood Thinners _____
- ❒ Insulin _____
- ❒ Antidepressants _____
- ❒ Cholesterol _____
- ❒ Other _____

Health Habits

Do you smoke? ❒ Often ❒ Sometimes ❒ Never

Do you drink alcohol? ❒ Often ❒ Sometimes ❒ Never

Do you drink coffee? ❒ Often ❒ Sometimes ❒ Never

Do you eat fast food? ❒ Often ❒ Sometimes ❒ Never

Do you exercise regularly?

❒ Never ❒ 1-3x/month ❒ 1-2x/week ❒ 3-5x/week

How much sleep do you get on average?

❒ Less than 5 hours ❒ 5-6 hours ❒ 7-8 hours ❒ 9+ hours

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deem appropriate.
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the 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 I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider or services rendered.

_____ _____
(Patient Signature) *(Date)* *(Guardian or Spouse's Signature)* *(Date)*

PREGNANCY RELEASE: This is to certify that to the best of my knowledge, I am not pregnant. Exodus Health Center has my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____ _____
(Date of Last Menstrual Period) *(Signature)* *(Date)*

Who should receive bills for payment for your account?
❒ Patient ❒ Spouse ❒ Parent
❒ Personal Health Insurance ❒ Auto Insurance

Ownership of X-ray Films
It is understood and agreed that the payments to the Doctor for the X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Awareness of Chiropractic Principles

Were you aware that…

Doctors of Chiropractic work with the nervous system?	❒ Yes	❒ No
The nervous system controls all organ systems and their functions?	❒ Yes	❒ No
Chiropractic is the largest natural healing profession in the world?	❒ Yes	❒ No
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	❒ Yes	❒ No
Has any *adult* in your family seen a Chiropractor?	❒ Yes	❒ No
Has any *child* in your family seen a Chiropractor?	❒ Yes	❒ No

EMERGENCY CONTACT

Name _____
Relationship _____
Work Phone _____
Home Phone _____

MY HEALTH INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company _____ Policy # _____

Address _____ Group # _____

Provider Phone Number _____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security # _____

Relationship _____ Date of Birth _____

Exodus Health Center

Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is the specific correction of vertebral subluxations.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand Exodus Health Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Exodus Health Center will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

_____ _____

(Signature) *(Date)*