First Name:

Middle Name:

Last Name:

Date of Birth:

Gender: ☐ Male ☐ Female

Height: Weight:

Marital Status: ☐ Single ☐ Married ☐ Divorced

Employment Status: ☐ Employed ☐ Full-time Parent ☐ Part-time Student ☐ Full-time Student ☐ Retired

Preferred Language:

Smoking Frequency: ☐ Never Smoked ☐ Light Smoker ☐ Heavy Smoker

☐ Former Smoker Started Smoking: Stopped Smoking:

Race: ☐ Do not wish to disclose

Ethnicity: ☐ Do not wish to disclose

Residential Address:

City, State, Zip Code:

☐ Home ☐ Cell Phone:

E-mail address:

Employer:

Occupation/Professional Title:

Spouse's Name:

Spouse's Phone:

Spouse's Employer:

Emergency Contact:

Emergency Home/Cell Phone:

Primary Care Physician or Clinic:
(If you do not have a Primary Care Physician, write none)

Address:

City, State, Zip Code:

Phone:

If you are utilizing insurance to cover a portion of the payment, please complete the following section:

Insurance Company: Plan Name:

Primary Insured Name:

Subscriber ID: Group Number:

Have you had similar symptoms before? ☐ No ☐ Yes If yes, when?

When did your symptoms start?

How did your symptoms begin?

Please describe your symptoms:

Pain level at its best: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Pain level on average: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Pain level at its worst: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How often do you experience symptoms?

☐ Intermittently 0-25% ☐ Occasionally 26-50% ☐ Frequently 51-75% ☐ Constantly 76-100%

What describes the nature of the symptoms?

☐ Sharp ☐ Dull ache ☐ Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐ Stiffness

How are your symptoms changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

On a scale of 0-100%, with 0% being completely unable to perform, and 100% being normal function:

How able are you to perform your normal work activities?

How able are you to perform your normal home activities?

How able are you to perform your normal recreational activities?

Who have you seen for your current symptoms?

☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

What treatment did you receive and when?

Which tests were performed for your symptoms and when?

X-ray date: MRI date:

CT scan date: Other & date:

Have you received treatment in the past for similar symptoms and who did you see?

☐ This Chiropractor ☐ Other Chiropractor ☐ Primary Care ☐ Physical Therapist ☐ Other

How did you hear about our office?

Who can we thank for your referral to our office?

If you did an online search, what did you search for?

Please select all that you currently have?		Have had in the past?	Additional Information:
Headaches	☐ Yes ☐ No	☐ Yes ☐ No	
Neck Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Upper Back Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Mid Back Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Low Back Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Shoulder Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Elbow/Upper Arm Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Wrist Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Hand Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Hip/Upper Leg Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Knee/Lower Leg Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Ankle/Foot Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Jaw Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Joint Swelling/Stiffness	☐ Yes ☐ No	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	
General Fatigue	☐ Yes ☐ No	☐ Yes ☐ No	
Muscular Incoordination	☐ Yes ☐ No	☐ Yes ☐ No	
Visual Disturbances/Dizziness	☐ Yes ☐ No	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	
Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No	
Chest Pains	☐ Yes ☐ No	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	
Bladder Infection	☐ Yes ☐ No	☐ Yes ☐ No	
Painful Urination	☐ Yes ☐ No	☐ Yes ☐ No	
Frequent Urination	☐ Yes ☐ No	☐ Yes ☐ No	
Loss of Bladder Control	☐ Yes ☐ No	☐ Yes ☐ No	
Prostate Problems	☐ Yes ☐ No	☐ Yes ☐ No	
Loss of Appetite	☐ Yes ☐ No	☐ Yes ☐ No	
Abdominal Pain	☐ Yes ☐ No	☐ Yes ☐ No	
Ulcer	☐ Yes ☐ No	☐ Yes ☐ No	
Abnormal Weight Change	☐ Yes ☐ No	☐ Yes ☐ No	
HIV/AIDS	☐ Yes ☐ No	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	
Liver/Gall Bladder Disorder	☐ Yes ☐ No	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	

Please select all that you currently have?		Have had in the past?	Additional Information:
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	
Chronic Sinusitis	☐ Yes ☐ No	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	
Excessive Thirst	☐ Yes ☐ No	☐ Yes ☐ No	
Drug/Alcohol Dependence	☐ Yes ☐ No	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	☐ Yes ☐ No	

Have any of your immediate family members had any of the following?

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus

Which family members had which conditions?

List all prescriptions, over-the-counter medications, and nutritional/herbal supplements you are taking:

List all surgical procedures you have had and how many times you have been hospitalized:

Additional Conditions:

Females only:

Birth Control Pills: ☐ Current ☐ Past

Hormonal Replacement: ☐ Current ☐ Past

Pregnancy: ☐ Current ☐ Past

Additional Conditions:

Please read thoroughly, initial the box to acknowledge each corresponding paragraph, and sign at the bottom of the form. Thank you.

☐ **Assignment of Benefits**

I assign all benefits payable to me for my care to Alpha Chiropractic. I understand that this health care facility will be paid directly by the insurance company or the other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

☐ **Guarantee of Payment**

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I fully understand and agree that if I cannot afford the standard fee, I, the patient, will be placed on a hardship Patient Plan. I will be responsible for reduced expenses to the office for services rendered to me.

☐ **Consent for Treatment**

I authorize the performance of diagnostic tests, procedures, and treatment deemed necessary by personnel involved in my care.

☐ **Privacy Practices (HIPAA)**

This health care facility recognizes that every patient has the Right of Privacy concerning his/her personal health information. We make every effort to protect and preserve patient records in a manner that secures this information. You do not give up any of your rights and you may choose at some point in the future to provide specific instruction for us to follow regarding your personal health information.

☐ **Authorization to Release Information**

I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

☐ **Information about Possible Risk of Chiropractic Treatment**

You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 1,000,000 treatments. Appropriate tests will be performed.

I acknowledge that I have received a copy of the privacy practices, which protects my information and health notes. A copy of these privacy practices is located on our website at: http://www.robertsonfamilychiro.com/Terms_of_Use.htm.

Signature of Patient or Responsible Party

Today's Date MM/DD/YYYY