



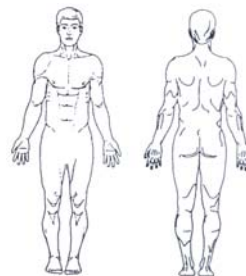
Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (_____) _____ Work Phone (_____) _____ Cell (_____) _____ Date of Birth _____ Age (_____)
 Referred by _____
 Occupation _____ Employer _____
 Marital Status Single Married Divorced Widowed Spouse's Name _____
 Spouse's Occupation _____ Number of Children & Ages _____
 Have you ever received Chiropractic Care? Yes No If yes, when, where, & why? _____
 Social Security # _____ E-Mail Address _____

Symptoms and Ill Health (Present State)

Major Complaint _____
 Pain or problem started _____
 Pains are Sharp Dull Constant Intermittent (frequency _____)
 Does the pain radiate? Yes No
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is the condition worse during certain times of the day? _____
 Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is the condition getting progressively worse? _____
 Other Doctors seen for this condition _____
 Any home remedies? _____
 Other symptoms:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Irritability	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Pins & Needles in Legs	<input type="checkbox"/> Pins & Needles in Arms
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Depression	<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Lights Bother Eyes	<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fainting	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Constipation	<input type="checkbox"/> Feet Cold
<input type="checkbox"/> Hands Cold		<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Buzzing in Ears			

Please indicate where your complaint is on the following diagram:



Please rate the pain on the following scale:
No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **The Worst Pain Ever**
 Have you been under drug and medical care? _____
 What medications are you taking? _____
 How Long? _____ Have you had surgery? _____ What _____ When _____



Introduction to the Office

Let us extend a warm and personal welcome to you on behalf of the 100% team! We want to provide you with the finest health care and we'll offer you many informative and entertaining educational opportunities.

First, you'll want to make informed decisions regarding your health. During the course of your care you'll be presented with several choices that will affect your ability to reach your individual health objectives.

Secondly, this information will be useful in making decisions about your health for the rest of your life.

To begin this process, here are a few important terms and procedures as you begin care:

On your first visit we will gather information about you through our examinations and consultations. There will be someone here to assist you in each step along the way. If you're not sure about what we need, just ask. Nothing will be done without your consent and full understanding.

We will be giving you information and clinical data in the form of literature, personal and media presentations. These are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

Just as we need to know about you, you should know about us. Chiropractic education currently consists of three years of pre-Chiropractic college education in the

biological sciences, followed by another five years of Chiropractic education and clinical internship. Then we are required to attend many hours of post-graduate education each year for license renewal. On top of this, our office is frequently involved in various seminars to keep abreast of the latest information.

We have minimized paperwork in our office. However, there are clinical forms that must be filled out accurately for your health, legal and professional reasons. We ask that you read a form through before completing it so you understand its intent. If you have questions, please ask.

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values.

- Treatment Only.** I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.
- Prevention.** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- Maintaining Health.** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- Family Health.** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.



Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature _____ Date _____

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature _____ Date _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period: _____

Signature _____ Date _____