

Precise Moves Chiropractic

Who referred you or how did you hear about our office? _____

Have you ever been under chiropractic care before? No Yes. If yes: When: _____ Reason: _____

PATIENT DATA (Please print legibly)

Name: _____ SS# _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Cell): _____ (Home) _____ (Work) _____

Age: _____ Birth Date ___/___/____ Sex M F Occupation: _____ Hrs worked per week: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

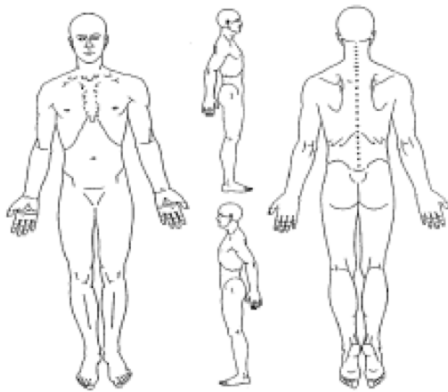
Current Complaints: Have you seen other doctors for this condition? No Yes

Reason for Visit: _____

How long has it been since you really felt good? _____

Is this condition due to an accident? No Yes. If yes what type? Auto Work Home Other _____

Mark an X on the picture where you have pain or discomfort. When did your symptoms first appear? _____



What caused this complaint? _____

What aggravates or makes the condition worse? _____

Is this condition getting progressively worse: Yes No Uncertain Other _____

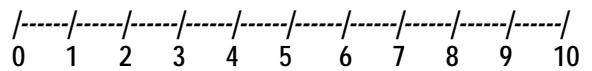
What relieves or makes the condition better? _____

Type of pain or discomfort? Sharp Dull Ache Numbness Shooting Tight Burning Tingling Swelling Stabbing Itching Throbbing Other _____

Overall Frequency of complaint: Constant (100% of the time) Frequent (75%) Intermittent (50%) Occasional (25%)

Does it interfere with Work Sleep Daily Routine Recreation Other: _____

Circle the severity of your pain at its BEST and at its WORST. Use the scale of Zero (no pain) to 10 (severe pain).



What are your hobbies (indoors & outdoors)? _____

How much time each day do you use the computer at work? _____ At home? _____

What makes you stressed? _____ How do you relieve it? _____

List 3 goals you want to achieve through chiropractic care:

1. _____ 2. _____ 3. _____

FINANCIAL AGREEMENT Do you have health insurance No Yes If yes: PPO HMO Other _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider (Precise Moves Chiropractic) for services rendered. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally and financially responsible for payment whether or not paid by insurance.

Patient or Guardian Signature

Date

Please check each of the conditions that you have now or had in the past.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shoulder Pain/Tingling |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Feet Pain/Tingling | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Arm Pain/Tingling | <input type="checkbox"/> Gout | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hand Pain/Tingling | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mid Back Problems | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pain that wakes you up
at night |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> (Men) Prostate Conditions |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hernia | <input type="checkbox"/> Numbness _____ | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Psychiatric Condition | |

For Women:

Is there a chance you are Pregnant? No Yes How many weeks? _____

Number of pregnancies? _____ Number of births? _____ Are you nursing? No Yes

Are you taking birth control pills? No Yes Do you have breast implants? No Yes

Do you suffer from PMS No Yes Do you have irregular cycles? No Yes

Do you experience painful periods? No Yes If yes, where is the pain? _____

<u>Injuries/Surgeries you have had:</u>	<i>Description</i>	<i>Date</i>
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

LIFESTYLE HABITS:

_____ Tobacco (# per day) _____ Coffee (cups per day) _____ Sleep (hrs per night) _____ Water (cups/day)

_____ Alcohol (drinks per day) _____ Tea (cups per day) _____ Soft Drinks (per day) Diet Regular

Exercise: Type _____ Frequency _____

Type _____ Frequency _____

FAMILY HISTORY Tell us about the major health conditions of your immediate family.

<i>Family Member Relation</i>	<i>Health Problem:</i>
_____	_____
_____	_____
_____	_____

MEDICATIONS List prescription, nonprescription, vitamins, minerals, herbs & supplements that you **currently** take.

Name:	Purpose:	How Long Taken?
_____	_____	_____
_____	_____	_____

Height _____ Weight _____