Name: _____ Date of Birth: _____ Age: _____
Your Address: _____ City: _____
State: _____ Zip: _____ SS #: _____ Cell #: _____
Name of Employer: _____ Home #: _____
Marital Status: S M W D Email#: _____
How Did You Hear About Us/Who Referred You? _____
How Many Children Do You Have? _____ What Are Their Ages? _____
Have You Or Any Other Members of Your Family Received Chiropractic Care? [ ] Yes [ ] No
How Long Has It Been? _____
Emergency Contact: _____ Phone #: _____
Who Is Responsible For Your Bill? [ ] Self [ ] Spouse [ ] Worker's Compensation [ ] Medicaid
[ ] Medicare [ ] Auto Insurance [ ] Personal Health Insurance [ ] Other: _____
Purpose Or Reason For Today's Appointment?_____
How Often Do You Drink Alcoholic Beverages? _____
Do You Smoke? [ ] Yes [ ]No How Much? _____
Do You Exercise? [ ] Yes [ ]No How Much? _____ Type? _____
Do You have Any Allergies? [ ] Yes [ ] No Specify: _____

Have you Ever Suffered From or Been Diagnosed As Having: (circle yes or no for each)

Y N *Broken or Fractured Bones
Y N Circulatory Problems
Y N Rheumatoid Arthritis
Y N Seizures/Convulsions
Y N A Congenital Disease
Y N Excessive Bleeding
Y N High/Low Blood Pressure
Y N Diabetes
Y N Epilepsy
Y N Pacemaker
Y N Strokes
Y N *Cancer
Y N Ulcers
Y N Ruptures
Y N Coughing Blood
Y N Osteoarthritis
Y N Eating Disorder
Y N Alcoholism
Y N Drug Addition
Y N HIV Positive
Y N Gall Bladder
Y N *Head Problems
Y N Depression
Y N Tumors

Explain: _____

Medication List

Name of Medication	Name of Vitamins	Date Started	Date Stopped

Healthcare Provider Team

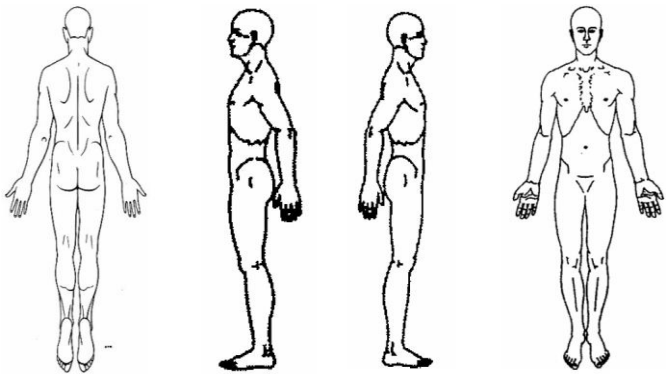
Other providers seen for the same condition:_____

Who is currently your
Chiropractor**:**_____
Primary Care Physician:_____
Physical Therapist: _____
Dentist: _____
Massage Therapist: _____
Personal Trainer: _____
Acupuncturist: _____
Health Club: _____
Other:_____

PATIENT HISTORY

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X. Sharp Pain



	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint	5th Complaint
Complaint:					
When did it start?					
On a scale of 1 -10 1 = mild 5 = moderate 10 = severe Rate your pain levels:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:
What % of the time does it occur?	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100
When does it occur most?	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____
How long does it last?	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant
What makes it better?					
What makes it worse?					

Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Walking	Y N	Kneeling	Y N	Grooming	Y N	Driving	Y N
Bending	Y N	Sitting	Y N	Standing	Y N	Exercising	Y N
Sleeping	Y N	Lifting	Y N	Running	Y N	Housework	Y N

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1. Have you ever had the condition(s) in the past? [ ] Yes [ ] No
   If yes, please indicate if any treatment was received and what type of treatment:
   [ ] Hospitalization [ ] Chiropractic care [ ]Medical doctor / specialty provider [ ] None
2. Have you ever lost time from work due to your condition(s)? [ ] Yes [ ] No
   If Yes, dates? _____
3. Are you pregnant? [ ] Yes [ ] No
4. What was the first day of your last menstrual cycle? _____
5. Number of pregnancies? _____ Number of miscarriages? _____

Patient Signature: _____ Date: _____

Systems Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the past. If neither apply, leave blank.

_____ High Blood Pressure
_____ Dizziness / Fainting
_____ Insomnia
_____ Low Resistance
_____ Tension
_____ Confusion
_____ Fatigue
_____ Ulcers
_____ Eye/Vision Problems
_____ Ear/Hearing Problems
_____ Difficulty Breathing
_____ Heart Problems
_____ Loss of Bladder Control
_____ Constipation
_____ Diarrhea
_____ Digestion Problems
_____ Nausea
_____ Female Problems
_____ Prostate Problems
_____ Diabetes
_____ Hands / Feet Cold
_____ Loss of Memory
_____ Nervousness
_____ Sweaty Palms
_____ Speech Difficulty
_____ Anxiety
_____ Depression
_____ Irritability

Anyone in your family have or had:

___ stroke ___ arthritis
___ cancer ___ hypertension
___ heart problems ___ diabetes

Please circle if you have any of the following:

_____ General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
_____ Skin	Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes
_____ Head	Trauma, headaches, dizziness, light headed
_____ Eyes	Changes in acuity photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____ Nose	Rhinorrhea, Epistaxis, allergies, airway obstruction
_____ Mouth & Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____ Neck	Stiffness, lumps / swelling / masses, pain
_____ Lungs	Cough (productive / nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
_____ Cardiac	Palpations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____ Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____ Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
_____ Gastrointestinal	Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, hematuria, sexually transmitted diseases, dyspareunia, scrotal swelling
_____ Genitourinary	Nocturnal polyuria, oliguria, dysuria, urgency, incontinence, urine color change
_____ Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation, history, pregnancy history, dysmenorrheal, premenstrual syndrome, climacteric
_____ Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement,/pain
_____ Musculoskeletal	Bone/joint pain, swelling, joint deformity, trauma, restricted ROM, weakness, atrophy
_____ Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, stasis, loss of balance, numbness, paresthesia
_____ Psychological	Mood swings, depression, anxiety, phobias

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Canton Chiropractic and Massage will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Canton Chiropractic and Massage. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____Date: _____

Guardian's Signature: _____ Date:_____

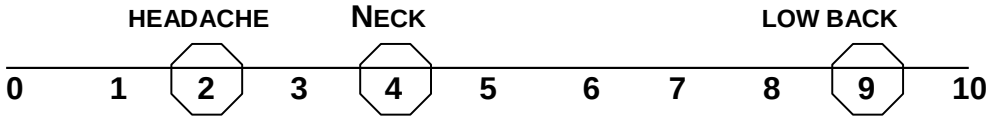
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Date _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:



****

1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

5. List three goals that you would like to see achieved.

- **1)**
- **2)**
- **3)**