ENHANCED LIVING
CHIROPRACTIC

Patient Data:

First Name:_______________________ Last Name:______________________ Date:___________

Telephone: (H):__________________(C)_____________________ Email:________________________

Date of Birth:________________ Social Security #:__________________

Mailing Address: ___________________________________ City: ________________ State:____ Zip:_____

Employer:___________________ Occupation:_________________ Marital Status: S M D W P

Spouse's Name: _______________________ Emergency Contact: _______________________

Emergency Contact #:_______________________ Referred by: _________________________________

Primary Care Physician: ______________________ Telephone: __________________________________

May we contact your physician regarding your treatment? No: ☐ Yes: ☐

Medical History:

Have you been treated for any conditions in the last year? ☐ No ☐ Yes, describe: _______________

____

Date of your last physical exam: ____________ is there a chance you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken recently? ☐ No ☐ Yes, where? _____________________________________

What medications or vitamins are you taking? For what conditions? ______________________________

Have you ever:	**No**	**Yes**	**Briefly Explain**
Broken Bones?	☐	☐	
Been Hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had sprains/strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

Family History:

Family Members-Present and past health conditions (ex: heart disease, cancer, diabetes, arthritis)

Current Health Condition:

Reason for today's visit: ____

Pains: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other, describe: ______________________________

____

Date of Injury: _____________________ Date Symptoms Appeared: ______________________________

Have you ever had the same condition? ☐ No ☐ Yes, When? _________________________________

List other practitioners seen for this injury/condition: _______________________________________

Have you ever been under chiropractic care? ☐ No ☐ Yes

1 2 3 4 5 6 7 8 9 10

Place an "X" on the line above to indicate level of pain

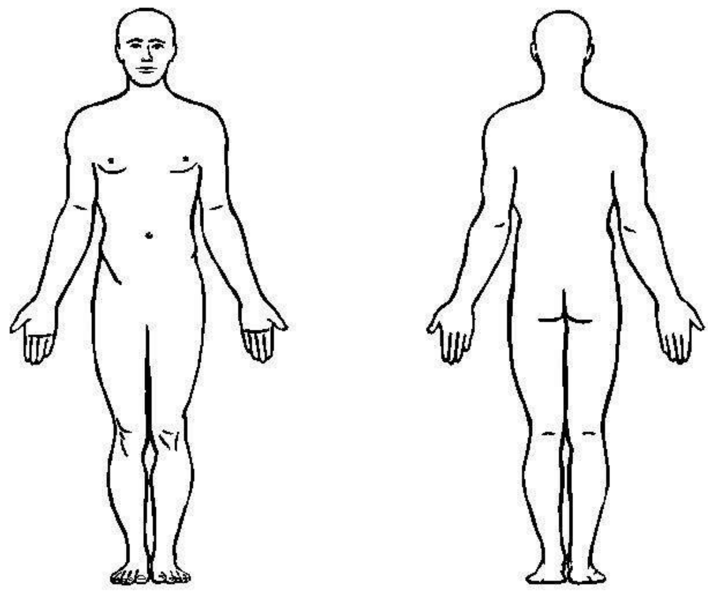
Other Symptoms: Check all that apply							
Headaches	☐	Face Flushed	☐	Fever	☐	Numbness in Fingers	☐
Neck Pain	☐	Stiff Neck	☐	Fainting	☐	Diarrhea	☐
Sleeping Problems	☐	Numbness in Toes	☐	Cold Sweats	☐	Feet Cold	☐
Back Pain	☐	Shortness of Breath	☐	Loss of smell/taste	☐	Hands Cold	☐
Nervousness	☐	Fatigue	☐	Pins & needles in legs	☐	Stomach Upset	☐
Tension	☐	Depression	☐	Pins & needles in arms	☐	Constipation	☐
Irritability	☐	Light Bothers Eyes	☐	Ears Ring	☐	Loss of balance	☐
Chest Pains	☐	Loss of Memory	☐	Dizziness	☐	Buzzing in Ear	☐

Question	No	Yes
Do you experience pain every day?	No ☐	Yes ☐
Is this pain getting progressively worse?	No ☐	Yes ☐
Do your symptoms interfere with daily life?	No ☐	Yes ☐
Do your symptoms cause problems with your occupation?	No ☐	Yes ☐
Are your symptoms worse during certain times of the day?	No ☐	Yes ☐
Do changes in the weather affect your symptoms?	No ☐	Yes ☐
Do you wear orthotics?	No ☐	Yes ☐

What activities aggravate your symptoms? What Activities lessen your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Past and Current Health Concerns		
Birth	**Growth & Development**	**Current**
Long Delivery ☐	Fall out of bed ☐	Organs removed/replaced ☐
Difficult Delivery ☐	Bang your head ☐	Teeth Problems ☐
Forceps ☐	Childhood sickness ☐	Eye Problems ☐
Breach/Cephalic ☐	Have any accidents ☐	Hearing Problems ☐
Mother given drugs during delivery ☐	Have surgery ☐	Physical stress ☐
Induced labor ☐	Fall down the stairs ☐	Mental stress ☐



Please use the following letters to indicate TYPE and location(s) of the symptoms you currently are experiencing.

A=Ache

B=Burning

S=Stabbing

N=Numbness

O=Other

P=Pins & Needles

As a result of my chiropractic care, I would like to:

☐ Feel better ☐ Have a healthier body by keeping my nerve system healthy

☐ Have a healthier spine ☐ Live a healthier lifestyle

Insurance Information:

Name of party responsible for payment: ___________________________ Telephone: ________________

Do you have health insurance? ☐ No ☐ Yes, Name of Company: _______________________________

***If an auto accident, please provide:**

Insurance Company Name: ______________________________ Contact Person: ___________________

Telephone: __________________________________ Claim #:___________________________________

Signatures:

Name of insured:

____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/ treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's initials: ________________ Guardian's Initials: ___________________

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Consent for Care in an Open Adjustment Environment:

I voluntarily consent to the rendering of care, including adjustments and conversations about adjustments and my care in an open adjustment environment. I understand that the open adjustment environment refers to a room in which other patients may be adjusted or waiting for care that may or may not have partial privacy barriers. I also understand that if at any time I desire care in a private room it will be made available upon request.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature _______________________________________ Date _________________________