Dynamic Family Chiropractic
Wellness Center

First Name_____ MI____ Last_____ Birth Date___/___/___ Age_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Home #( )_____ Cell # ( )_____ E-mail Address_____

Can we send you occasional text messages for important reminders? _____Yes _____No

_____Male _____Female # of Children_____ Single Married Widowed Divorced

Employer_____ Occupation_____ ***WOMEN ONLY***: *Are you pregnant? NO___ YES___*

Name of Spouse (parent if patient is under 18)_____ Birth Date of Spouse (parent if patient is under 18)_____

Who may we thank for referring you to our office?_____

Patient's Health Profile

Please check the appropriate box for any of the following symptoms which you now have or have had in the past. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

____ Fractured Bones	____ Allergies	____ Hearing Loss R or L	____ Pacemaker
____ Auto Accidents	____ Sinus Problems	____ Fainting	____ Stroke
____ Other Accidents/Falls	____ Eating Disorders	____ Blurred/Double Vision	____ High/Low Blood Pressure
____ Back Curvature	____ Trouble Sleeping	____ Upper Back Pain/Stiffness	____ Varicose Veins
____ Arthritis	____ Thyroid Problems	____ Trouble Concentrating	____ AIDS/HIV
____ Diabetes	____ Learning Disability	____ Low back Pain/Stiffness	____ Liver Trouble
____ Swollen/Painful Joints	____ Mood Changes	____ Numbness/Tingling	____ Digestive Problems
____ Convulsions/Epilepsy	____ Headache	____ Gall Bladder Problems	____ Pain/Stiff Neck R or L
____ Skin Problems	____ Heartburn	____ Pain with cough, sneeze	____ Mid Back Pain/Stiffness
____ Cancer	____ Hip Pain R or L	____ Ulcers/Colitis	____ Diarrhea/Constipation
____ Chemotherapy	____ Foot Trouble R or L	____ Colon Trouble	____ Hemorrhoids
____ Depressed	____ Asthma	____ Prostate Problems	____ Head/Shoulders Feel Tired
____ Irritable	____ Lung Problems	____ Impotence	____ Shoulder Pain R or L
____ Anemia	____ Dizziness	____ Difficulty Breathing	____ Kidney Problems
____ Tremors	____ Ear Infection	____ Heart Problem	____ Hepatitis (A, B, C)
____ Alcohol/Drug Abuse	____ Bed Wetting	____ Ringing in Ears R or L	

FOR WOMEN ONLY:

Are you pregnant?	____ Y ____ N	Are you Nursing?	____ Y ____ N
Are you taking birth control?	____ Y ____ N	Do you experience painful periods?	____ Y ____ N
Do you have irregular cycles?	____ Y ____ N	____ Infertility Problems	____Menopausal Problems

Reason For This Visit

Chief Complaint (why are you here today):_____

_____

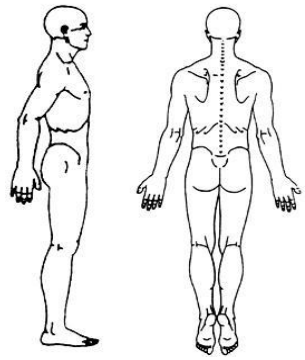
How long has this condition persisted? _____

Have you seen other doctors for this condition? _____

Dr.'s Name(s) _____

Results _____

Name of Previous Chiropractor _____



*Circle the areas you have problems.

Symptoms:

The pain is located _____ When did this condition begin? _____

The condition is: ___ Mild ___ Moderate ___ Severe ___ Constant ___ Intermittent ___ Other

Does this pain travel or radiate? If so, where? _____

Quality: (mark all that apply)

___ Burning ___ Dull/Aching ___ Localized ___ Sharp ___ Tingling ___ Radiating

Timing:

___ Worse AM ___ Worse PM ___ Worse W/ Activity ___ Worse Sleeping

Is there anything that makes this better or worse? _____

On a scale of 1-10 rate your pain : **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Severe Pain**

Past & Social History:

Medication:

___ Nerve Pills _____
___ Pain Killers _____
___ Muscle Relaxers _____
___ Blood Pressure Medication _____
___ Blood Thinners _____
___ Insulin _____
___ Antidepressants _____
___ Cholesterol _____

Health Habits:

Do you smoke? ___ Often ___ Sometimes ___ Never
Do you drink alcohol? ___ Often ___ Sometimes ___ Never
Do you drink coffee? ___ Often ___ Sometimes ___ Never
Do you eat fast food? ___ Often ___ Sometimes ___ Never
Do you exercise regularly?
___ Never ___ 1-3x/month ___1-2x/week ___3-5x/week
How much sleep do you get on average?
___ Less than 5 hours ___5-6 hours ___7-8 hours ___9+hours

Goals for My Care:

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for their correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

___ **Relief Care:** Symptomatic relief of pain or discomfort.
___ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
___ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health.
___ I want the doctor to select the type of care appropriate for my condition.

On a scale from 1 to 10, with 10 being the highest, rate your level of commitment in helping us solve this problem:

(Circle One) 1 2 3 4 5 6 7 8 9 10

Health Care Goals: (Check all that apply)

___ Pain Relief ___ Prevent Injury & Disease ___ Increase Overall Function

___ Weight Loss ___ Healthy Nutrition ___ Decrease Sickness

___ Other: _____

Dynamic Family Chiropractic Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Our philosophy involves "open-bay" adjusting. Should you have personal questions, we do have adequate space for that.

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 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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 services 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Dynamic Family Chiropractic Policies / Procedures:

(Please Initial Next to each Line)

_____ 1. All initial services and subsequent fees are payable when services are rendered. (Co-pays, deductibles, etc.) Failure to pay will result with balances being transferred to a collection agency.

_____ 2. X-ray films / discs are the property of Dynamic Family Chiropractic. Once films are used for treatment purposes, they cannot be released. Copies can be made, if necessary with a **$10.00 processing fee** and will be ready for pick-up within **24 hours** of the time requested.

_____ 3. If Medical Records are requested there will be a copy / processing fee of **ten cents per page** and will be ready for pick up within **24 hours** of time requested.

_____ 4. I have read and understand The Notice of Privacy Act (HIPPA forms, behind New Patient Paperwork) and a copy will be provided to me if requested.

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 begin my chiropractic examination and any other further care on this basis.

_____ _____
(Signature) (Date)

_____ _____
(Staff Signature) (Date)