Welcome To Healthy Roots Chiropractic

How did you hear about our office? _____

Have you ever been under chiropractic care before? ❑No ❑Yes Reason: _____

PATIENT DATA (Print Legibly)

Name _____ Email _____

For general office announcements and promotions ONLY.

Address _____ City _____ State _____ Zip _____

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

Age _____ Birth Date _____ Occupation _____ Hrs worked/wk _____

Emergency Contact _____ Relationship _____Phone _____

Social Security #: _____ - _____ - _____

Insurance Information

❑Health Insurance ❑Auto/PI ❑Work Comp ❑Slip/Fall ❑Other

Insurance Company Name _____

Plan ID#_____ Group ID#_____

Insurance Company Address _____

City _____ State _____ Zip _____

Is the Patient Primary Insured? ❑Yes ❑No (If Yes, please skip next 2 lines)

Patient Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other_____

Insured Name_____ Insured Birth Date _____ Insured Legal Gender ❑M ❑F

Insured Full Address _____ Phone_____

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 (New Life Chiropractic) for services rendered. **I clearly understand and agree that all services rendered 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 of 1st Visit

Accident/Illness Information

Is this condition related to ❑ Employment ❑ Auto Accident ❑Other Accident:_____

Date of Accident ____/_____/_____ Dates missed from work:_____

Current Complaints

Reason(s) for today's visit:_____

How long has it been since you felt good? _____

Date current Symptoms Started ____/_____/_____

Describe what happened:_____

_____

Do you get headaches? ❑Often ❑Sometimes ❑Not at all

Headache Pain Location:❑Entire Head ❑Left Back of Head ❑Right Back of Head ❑Front of Head ❑Left Side ❑Right Side ❑Behind the Eyes ❑Left Temple ❑Right Temple ❑Top of Head

Please Check Your Symptoms and indicate their location on the figures below

❑Sharp

❑Dull

❑Ache

❑Numbness

❑Shooting

❑Tight

❑Burning

❑Tingling

❑Swelling

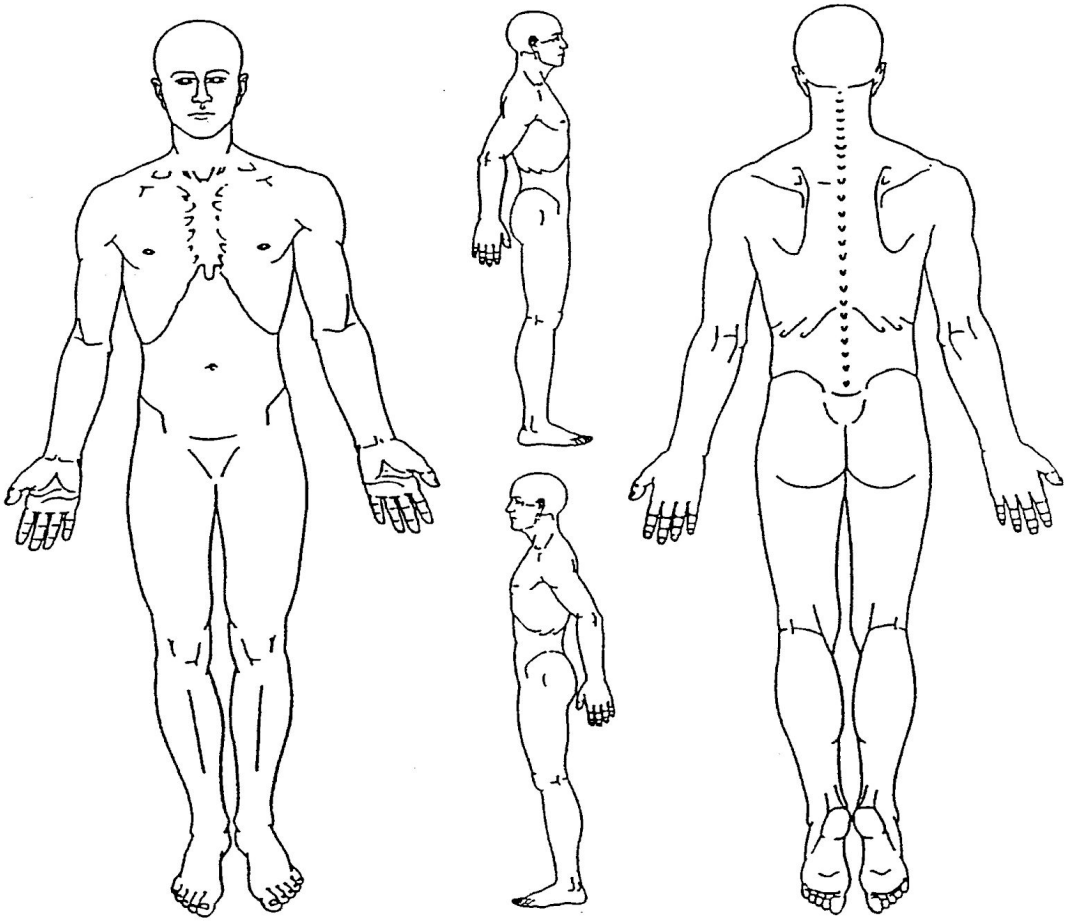
❑Stabbing

❑Itching

❑Throbbing

❑Other

_____



Other Symptoms:

_____

_____

Circle the severity of your pain at its BEST and at its WORST.

What aggravates or makes the condition worse? _____

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

What relieves or makes the condition better? _____

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

Have you experienced these symptoms before? ❑No ❑Yes Started: _____ Resolved: _____

Did you receive treatment for these symptoms? ❑No ❑Yes

If you received treatment from anyone, please provide their name and address

❑Chiropractor ❑ER _____

❑MD ❑ND _____

❑Chronic Pain ❑PT

_____

Specialist

_____

❑Other _____

When finished with treatment, how would you describe your symptoms?

❑Completely Gone ❑Not Changed by Tx ❑ ❑Not as Severe ❑Less frequent Symptoms ❑Other _____

Other Comments: _____

_____

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

What are your hobbies (indoors & outdoors)? _____

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

What makes you stressed? _____ What makes you happy? _____

List 3 goals you want to achieve through chiropractic care:

1. _____ 2. _____ 3. _____

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

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

For Women:

Is there a chance you are Pregnant? ❑No ❑Yes How many weeks? _____
Are you nursing? ❑No ❑Yes
Are you taking birth control pills? ❑No ❑Yes
Do you experience painful periods? ❑No ❑Yes Where is the pain? _____
Do you suffer from PMS ❑No ❑Yes
Do you have irregular cycles? ❑No ❑Yes
Number of pregnancies? _____ Number of births? _____
Are you in menopause? ❑No ❑Yes If Yes how long? _____

Injuries/Surgeries you have had:	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones/Dislocations		
Surgeries		

Lifestyle Habits:

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

Alcohol* (drinks/day) _____ Tea (cups/day) _____ Soft Drinks (cans/day) _____ ❑Diet or ❑Regular

Exercise: Type _____ Frequency _____

_____ _____

_____ _____

*1 Drink = 1.5oz liquor, or 12oz beer, or 6oz wine

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

Family Member Relation:	**Health Problem:**

_____ _____

MEDICATIONS TAKEN NOW	List prescription, nonprescription, vitamins, minerals, herbs & supplements etc.

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

Height: _____ Weight: _____