



ABOUT YOU

NAME		DATE OF BIRTH	AGE
ADDRESS			
CITY		STATE/ZIP CODE	
PHONE 1 HOME / CELL / WORK		PHONE 2 HOME / CELL / WORK	
BEST NUMBER TO REACH YOU? HOME ____ CELL ____ WORK ____			
MAY WE LEAVE A MESSAGE? ____ CELL CARRIER: _____			
MAY WE SEND BI-MONTHLY APPT. TEXT REMINDER ____			
MAY WE EMAIL YOU PERSONAL HEALTH INFO AS NEEDED? ____			
EMAIL ADDRESS: _____			
EMPLOYER NAME		NUMBER	
OCCUPATION	GENDER		
MARITAL STATUS	PAYMENT METHOD ☐ CASH ☐ CHECK ☐ CREDIT CARD		
SPOUSE NAME	BEST PHONE #		
SPOUSES EMPLOYER	NUMBER		
PRIMARY DOCTOR	PHONE		
LAST VISIT	LAST PHYSICAL		

EMERGENCY CONTACT

NAME	RELATIONSHIP
BEST PHONE #	ALT. PHONE #

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY) ☐ NEWSPAPER ☐ SIGN ☐ FACEBOOK ☐ COMMUNITY EVENT ☐ MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME
APPROXIMATE DATE OF LAST VISIT
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HEALTH HABITS

DO YOU SMOKE? ☐ YES ☐ NO How much per day _____ How many years? _____
ALCOHOL CONSUMPTION - HOW MUCH _____ HOW OFTEN? _____
DO YOU DRINK COFFEE, TEA OR SODA? _____ How much per day _____
DO YOU EXERCISE REGULARLY? ☐ YES - TYPE _____ ☐ NO
DO YOU WEAR ☐ HEEL LIFTS ☐ SOLE LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO AN ACCIDENT ☐ JOB ☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY DATE _____ ☐ CHRONIC DISCOMFORT ☐ OTHER PLEASE EXPLAIN
TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? ☐ AUTO INS ☐ WORKER'S COMP ☐ OTHER
WHEN DID THE SYMPTOMS BEGIN? RATE YOUR WORST PAIN ON A SCALE OF 1-10 ____ ON A GOOD DAY ____ TYPE OF PAIN (mark all that apply) Sharp ____ Dull ____ Throbbing ____ Aching ____ Shooting ____ Numb ____ Burning ____ Tingling ____ Cramps ____ Stiffness ____ Other ____ IS IT CONSTANT ____ INTERMITTENT ____
HAS THIS CONDITION ☐ WORSENER ☐ STAYED CONSTANT ☐ COME AND GONE
DOES THIS CONDITION INTERFERE WITH ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES ACTIVITIES THAT ARE PAINFUL TO PERFORM SITTING ____ STANDING ____ BENDING ____ WALKING ____ LYING ____ OTHER ____
HAS THIS CONDITION OCCURRED BEFORE? ☐ YES ☐ NO PLEASE EXPLAIN
WHO HAVE YOU SEEN FOR THIS CONDITION? DOCTOR'S NAME NAME _____ PHONE _____ ADDRESS _____
TYPE OF TESTS MRI ____ X-RAY ____ TREATMENT Meds ____ Surgery ____ Phys. Therapy ____ Chiropractic ____
RESULTS WHERE WAS IT DONE

NAME _____

ALLERGIES

ENVIRONMENTAL / FOOD / MEDICATIONS

SURGERIES

MEDICATIONS / SUPPLEMENTS

YOUR CONCERNS

INSTRUCTIONS Place an X by the concerns or conditions you may be experiencing **NOW**. Each area of concern relates to an area of the spine and nerve function.

Sore throat _____
Stiff neck _____
Radiating arm pain _____
Hand / Finger _____
Numbness _____
Asthma _____
Allergies _____
Blood pressure _____
Heart conditions _____
Thyroid _____

Mid Back _____
Congestion _____
Breathing _____
Bronchitis _____
Pneumonia _____
Gallbladder _____
Stomach _____
Ulcers _____
Gastritis _____
Kidney _____

Constipation _____
Colitis _____
Diarrhea _____
Gas pain _____
Irritable bowel _____
Bladder _____
Menstrual issues _____
Low back pain _____
Leg pain _____
Numbness in legs _____
Reproductive _____

C1 Headaches _____
C2 Migraines _____
C3 Dizziness _____
C4 Sinus _____
Allergies _____
Fatigue _____
Head colds _____
Vision _____
Difficulty _____
Concentrating _____
Hearing _____
Jaw _____

T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

L1
L2
L3
L4
L5
S
A
C
R
A
L

OTHER

HEALTH HISTORY

Check and LIST WHO IT APPLIES TO: Do you or your family members have—or had in the past, any of the following: (While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.)

- | | | | |
|--|---|--|--|
| ☐ SEVERE OR FRE-
QUENT HEADACHES | ☐ A-FIB | ☐ DIABETES | ☐ LOWER BACK PROBLEMS |
| ☐ EPILEPSY | ☐ STROKE | ☐ THYROID PROBLEMS | ☐ FREQUENT NECK PAIN |
| ☐ DIZZINESS /TINNITIS | ☐ HEART ATTACK | ☐ ASTHMA / BRONCHITIS | ☐ PAIN BETWEEN
SHOULDERS |
| ☐ ANXIETY | ☐ PACEMAKER | ☐ DIGESTIVE PROBLEMS | ☐ DIFFICULTY BREATHING |
| ☐ SHINGLES | ☐ HIGH BLOOD PRES-
SURE | ☐ ULCERS/COLITIS | ☐ SLEEP PROBLEMS |
| ☐ ARTHRITIS | ☐ CONGENITAL HEART
DEFECT | ☐ KIDNEY PROBLEMS | ☐ SINUS PROBLEMS |
| ☐ TUBERCULOSIS | ☐ RHEUMATIC FEVER | ☐ URINARY PROBLEMS | ☐ OTHER: |
| | ☐ CANCER | ☐ HIV / AIDS | |
| | | ☐ HEPATITIS | |

FOR WOMEN ONLY

PREGNANT? _____
DUE DATE? _____

NURSING? _____
ARE YOU TAKING BIRTH
CONTROL? _____
HAVE HORMONE IMPLANTS? _____
HAVE PAINFUL PERIODS? _____

HAVE IREEGULAR
CYCLES? ☐ YES ☐ NO

HAVE BREAST IMPLANTS
☐ YES ☐ NO

AUTHORIZATION FOR CARE

I hereby authorize Dr Allen to work with my condition using recommended protocols as she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

SIGNATURE

DATE

GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE

DATE

FINANCIAL POLICY / NO SHOW FEE

Payment is expected at time of service. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at time of service. I agree that I am responsible for all bills incurred at this office.

- Your health care is very important to us. **We expect you to keep scheduled appointments.**
- **Late arrival may require your appointment to be rescheduled.**
- **Should you need to reschedule, however, please call our office 24 HOURS in advance to avoid being charged our regular office fee.**
- *Please understand that someone else in pain may need that time. We appreciate your cooperation in this matter. We manage our schedule to keep you and others from waiting a long time.*

SIGNATURE

DATE

GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE

DATE

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT)

RELATIONSHIP TO PATIENT

SIGNATURE

DATE