



Name _____ Preferred Name _____

Address _____

City/State/Zip _____

Home Phone (_____) _____ Cell (_____) _____

Is it ok to contact you at work? Yes No Work #(_____) _____

Birthday _____ Age _____ SS# _____

E-Mail address _____

Occupation _____ Employer _____

Marital Status: Single Married Separated Divorced Widowed

Spouse's name _____ Phone # _____

Children's names and ages _____

Emergency Contact: Name _____ Relationship _____

Phone number (_____) _____

Are you pregnant? Yes No If yes, what month? _____

What Brings You Here?

Have you ever had chiropractic care before? Yes No

If yes, reason for those visits? _____

Doctors name _____ Where you pleased with your care? Yes No

How did you find out about our office? _____

Is this appointment related to: Work Sports Auto Fall Home Injury

When did incident occur? _____

Attorney (if applicable) _____

Attorney # (_____) _____ Contact person _____

Are you receiving care from other health professionals? Yes No

If yes, please name them and their specialty _____

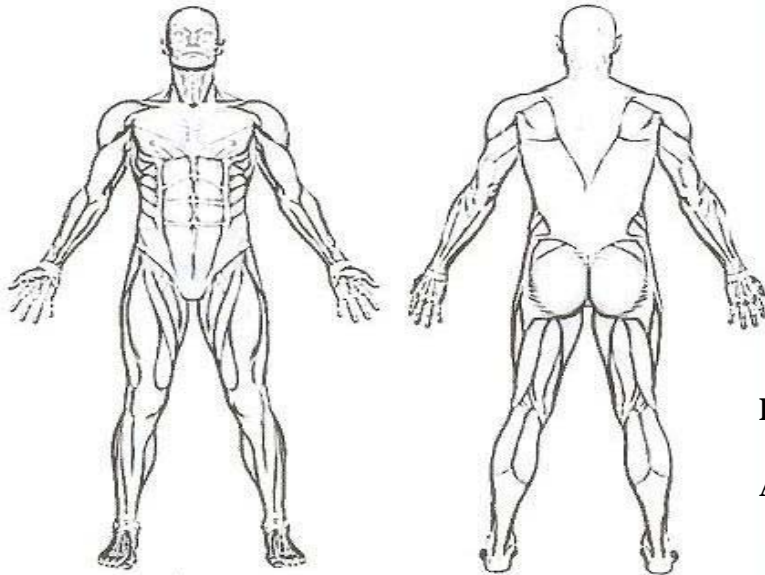
Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homeopathics/other you are taking _____

What are your most pressing health concerns? _____

For how long? _____ **Has condition** gotten worse stayed constant comes and goes

Where is the problem? Please use the illustrations and lines below to explain.



Front _____

Back _____

Do you have Pain Numbness Tingling

Are your symptoms affected by Sitting Walking
 Bending Lying down Standing

Does this condition interfere with Work Sleep
 Daily Routine Other activities

Please explain _____



Do you smoke? Yes No

Do you drink alcohol? Yes No

Do you drink coffee? Yes No

Do you use artificial sweeteners? Yes No

Do you use recreational drugs? Yes No

Health History

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|---|---|---|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart surgery/ Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low Blood pressure | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Pain between the shoulder blades | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Sleep |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Numbness or Tingling in
Arms/Legs/Hands | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Attack/ Stroke |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis |
| | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken pox |

Have you ever:

- | | | |
|---------------------------|-----|----|
| Broken bones? | Yes | No |
| Been hospitalized? | Yes | No |
| Been in an auto accident? | Yes | No |
| Been struck unconscious? | Yes | No |
| Had sprain/strains? | Yes | No |

Briefly Explain

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 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 possible with chiropractic.
- I want the Doctor to select the type of care appropriate for my condition.

Were you aware that...

Doctors of Chiropractic work with the nervous system?	Yes	No
The nervous system controls all bodily functions and systems?	Yes	No
Chiropractic is the largest natural healing profession in the world?	Yes	No
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	Yes	No

Financial Responsibility

How will you pay for your care? (Check) (Cash) (Credit Card) (Insurance)

Insurance Co. _____ Subscriber # _____

Group Policy # _____ Customer Service # (____) _____

Name of Insured _____ DOB ____/____/____ Relation _____

Address _____ City _____ State ____ Zip Code _____

Insured's Employer _____ Insurance type: **(PPO) (POS) (HMO)**

Office Policies: If I am accepted as a patient to the Complete Health Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. In the event that I receive checks from my insurance company or from Third-Party insurance for services rendered at Complete Health Chiropractic, I understand that I am fully responsible for providing payment to the provider immediately. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

Consent For X-Ray (If Needed): I authorize Complete Health Chiropractic to do an X-Ray examination if needed.

Consent To Treat: I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Cody or Dr. Comer to proceed with any necessary treatment.

I have read the office policies and consent to treat information, and I agree with them by signing below:

Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____