Mission Chiropractic

STEP 1

PERSONAL HISTORY

NAME: DATE: / /

ADDRESS:

CITY STATE: ZIP:

HOME PHONE #: CELL #:

WORK #:

SOCIAL SECURITY #:

BIRTH DATE: / / AGE: SEX: M F

HEIGHT: WEIGHT:

MARITAL STATUS: SINGLE MARRIED SPOUSE'S NAME:

DRIVERS LICENSE #: EXP DATE: STATE:

EMAIL:

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

CONSENT TO CARE FOR A MINOR CHILD

I hereby authorize **Mission Chiropractractic** to administer healthcare services as they deem necessary to my children.

Signature _____

FEMALE PATIENTS ONLY

I declare that to the best of my knowledge I am not pregnant and I submit to spinal x-ray analysis for diagnosis of my condition. I will hold **Mission Chiropractic** harmless if I fail to report this information.

Signature _____

FINANCIAL RESPONSIBILITY

I am solely responsible for any changes or fees associated with my health care services, and I will be advised of all changes prior to execution of any services.

Signature _____

WHILE TODAY IS COMPLIMENTARY,
PLEASE GIVE THE RECEPTIONIST A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARD (if insured) SO COPIES CAN BE MADE FOR YOUR FILE.

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STEP 2

In order for us to better serve you, please provide detailed answers to the questions below

1.) In your own words, what is the primary reason for coming to our office. (in detail)

_____

_____

2.) Please describe the location and sensations of your symptoms (in detail) (examples: Weakness, Tingling, Numbness, Pins and Needles, Burning, Aching, Stabbing, Shooting)

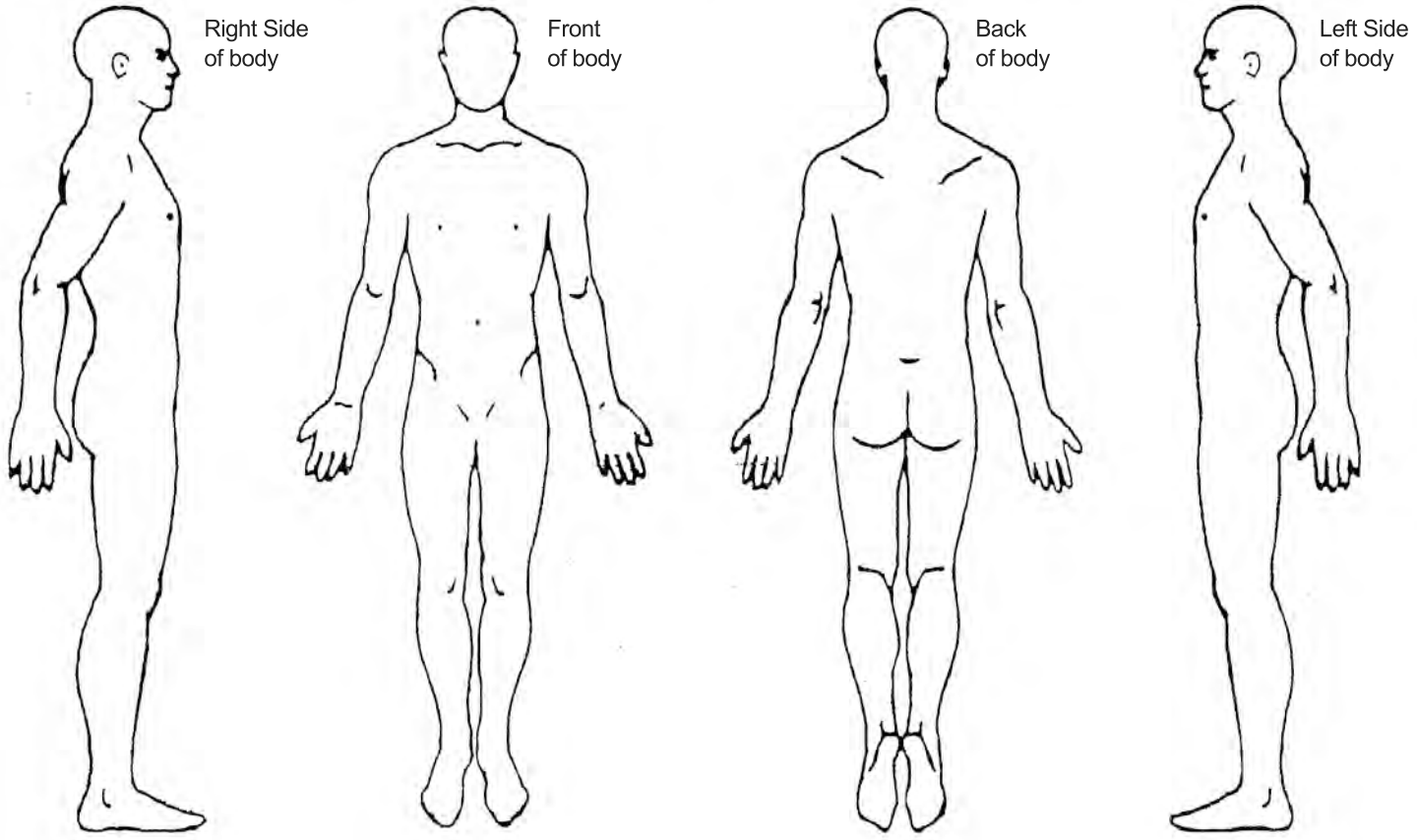
_____

_____

3.) Please mark the area(s) of injury or discomfort on the illustration below using the appropriate symbols.

Description →	Weakness	Tingling	Numbness	Pins & Needles	Burning	Aching	Stabbing	Shooting
Use Symbol →	W	T	N	P	B	A	ST	SH

Draw a circle ◯ around any area of pain not represented by a symbol.



4.) On a scale from 0 to 10, grade the severity of each of the above symptoms separately. (”0” being no discomfort and “10” being extreme discomfort)

_____

5.) When did you first begin to notice the symptoms?

_____

6.) Have you ever had these symptoms before? (When? How often?)

_____

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STEP 3

Please use the space provided to explain in detail any information to clarify any of the checked off conditions below.

Have You or any Family member had any of the following: (S for Self or F for family member)

___ Bone Fractures of any Kind
___ Arthritis
___ Skin or Rash problems
___ Colds & Flu Shots
___ Seasonal Allergies or Allergic Reactions
___ Sinus or Ear Infection
___ Menstrual cramps
___ Pre-Menstrual Syndrome
___ Hysterectomy
___ Hormone Imbalances
___ Hormone Replacement Therapy
___ Thyroid Condition
___ Enlarged Prostate
___ Impotence or loss of libido
___ Stomach Acid reflux or Esophageal Reflux
___ Dizziness, Liqhtheadedness or Vertigo
___ Digestion Problems
___ Bleeding Ulcers or Bleeding Gastritis
___ Urine or Stool Incontinence
___ Diarrhea or Constipation
___ Headaches (Tension, Stress. Hormonal)
___ Neck pain or stiffness
___ Numbness, Pain or Tingling in the shoulder, arms, elbows, hands, or Fingers
___ Numbness, Pain, or tingling in the buttocks, thighs, knees, legs, feet, toes
___ Coldness or Heat found in the Hands or Feet
___ Jaw pain (TMJ)
___ Mid back Pain or Stiffness
___ Low back Pain or Stiffness

___ Blood in Urine or Stool
___ Chest Pain
___ Heart conditions of Any Kind
___ Emphysema or Asthma (circle one)
___ Congestion or Pneumonia
___ Cancer of Any Kind
___ Diabetes type 1 or 2 (circle one)
___ Seizures, epilepsy
___ Stroke
___ High/low blood pressure
___ Liver conditions
___ Gall bladder conditions
___ Kidney conditions
___ Pregnancy (Prior)
___ AIDS. HIV
___ Depression
_ Anxiety
_ ADD / ADHD
_ Coughing, Sneezing, or Bowel Movements (with Pain)
_ Daily Fatigue
_ Blood Disorders
_ General Muscle Aches or pains
_ Appendicitis
_ Unexplained Weight Loss or Gain
_ Loss of smell or taste
_ Ringinq in Ears Right Left
_ Loss of Hearing Right Left
_ Loss of vision, blurred Right Left
_ Doubled vision Right Left
_ Hip joint pain or replacement Right Left
_

Physicians Notes