TAYLOR CHIROPRACTIC

HEALTH | WELLNESS | PERFORMANCE

Patient Information

General Information

Date:_____

Patient Name:_____ **Date of Birth:**_____

Patient Sex: M F **Age:**_____ **Email:**_____

Address:_____

City: _____ **State:**_____ **Zip:** _____

Cell #:_____ **Home #:**_____ **Work#:**_____

Patient Employer:_____ **Patient Occupation:**_____

How did you hear about us?_____

Complaint History

Describe your current complaint and how the problem began:_____

_____

How long have you had this condition?_____ **Date of onset:**_____

How would you describe the pain? (Circle all that apply)

Sharp Soreness Throbbing Tingling Dull Stiffness
Spasm Burning Ache Weakness Numbness Shooting

How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
(no pain) (moderate pain) (terrible/unbearable pain)

How often is the pain present?

Constant(81-100%) Frequent(51-80%) Occasional(25-50%) Intermittent(25% or less)

Since the problem began, is the pain:

Getting worse Getting Better Staying the same

What makes your pain better?

Nothing Walking Sitting/Standing Exercise Lying Down Computer use

What makes your pain worse?

Nothing Walking Sitting/Standing Exercise Lying Down Computer use

Complaint History- continued

Are you currently taking any medications? **Yes** **No**

If yes, please describe: _____

_____

Were you previously treated for an earlier occurrence of this same condition? **Yes** **No**

If yes, by whom? MD Chiropractor Physical Therapist Other

Are you aware that we are specialist in treating Auto Accident and Slip & Fall cases? Yes No

Do you know someone that has been in a recent accident that needs care? Yes No

What is your physical activity at work?

Mostly sitting Light manual labor Moderate manual labor Heavy manual labor

Do you exercise?

No regular exercise 1-2 times a week 3-4 times a week 5-7 times a week

What is your present general stress level?

No stress Minimal stress Moderate stress Greatly stressed

Are you interested in any of the following additional services that we offer?(Circle all that apply)

Nutritional Supplementation Massage Therapy Medical Weight Loss Trigger Point Therapy

Food Sensitivity/Allergy Testing Wellness Blood Panel B12 Injections Dry Needling/Cupping

Past or present symptoms, conditions or habits

Below is a listing of symptoms, conditions or habits. Please circle indicating whether this applies to past or present.

Symptom			Symptom		
Neck pain	**Past**	**Present**	High blood pressure	**Past**	**Present**
Shoulder Pain	**Past**	**Present**	Respiratory Condition	**Past**	**Present**
Arm/Elbow Pain	**Past**	**Present**	Digestive Problems	**Past**	**Present**
Hand Pain	**Past**	**Present**	Kidney/Bladder Problem	**Past**	**Present**
Upper Back Pain	**Past**	**Present**	Sinus Conditions	**Past**	**Present**
Lower Back Pain	**Past**	**Present**	Allergies/Asthma	**Past**	**Present**
Pain in Upper Leg or Hip	**Past**	**Present**	Cancer	**Past**	**Present**
Pain in Lower Leg or Knee	**Past**	**Present**	Stroke	**Past**	**Present**
Pain in Ankle or Foot	**Past**	**Present**	Excessive Weight Loss/Gain	**Past**	**Present**
Jaw Pain	**Past**	**Present**	Skin Condition	**Past**	**Present**
Swelling/Stiffness of Joints	**Past**	**Present**	Arthritis	**Past**	**Present**
Headaches	**Past**	**Present**	Diabetes	**Past**	**Present**
Dizziness	**Past**	**Present**	General Prolonged Fatigue	**Past**	**Present**

Past or present symptoms, conditions or habits- continued:

Tobacco Use: Past Present Occasional Moderate Heavy

Alcohol Use: Past Present Occasional Moderate Heavy

Caffeine Use: Past Present Occasional Moderate Heavy

Pregnancy: Past Present

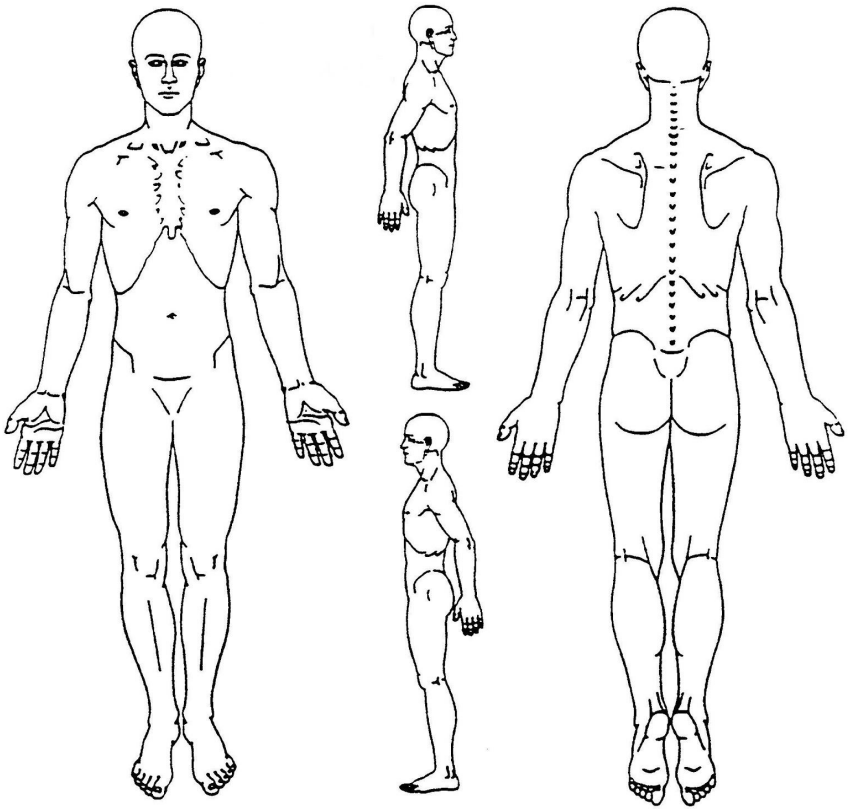
Surgical Procedure: Past Present

Please list:_____

Allergies:_____

Emergency Contact: _____ Phone #:_____

Please mark your areas of pain with "X's"



Authorization and Releases

Name:_____

Consent for Treatment

I, the undersigned, hereby authorize the doctor(s) and whomever they may designate as their assistant to perform diagnostic tests, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

_____

Patient Signature **Date**

Authorization to Release Medical Information

I authorize the doctor(s) to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic, Taylor Chiropractic & Wellness is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

_____

Patient Signature **Date**

Consent for Treatment of Minor (if applicable)

I hereby authorize the doctor(s) and whomever they may designate as their assistant(s) to perform diagnostic tests, and to administer treatment as they deem necessary for my _____(Indicate relationship to child. ie: daughter, son, etc.) (Child's name)_____

_____

Parent/Guardian Signature **Date**