Why this form is so important:

The vast majority of chiropractic offices tend to have a focus on the relief of neck pain, back pain, or personal injury management.

Chiropractic Today is not your typical chiropractic office… Be happy you chose to come here.

As a Wellness Center, our focus goes beyond initial treatment of your pain and centers around your natural, God-given ability to reach peak levels of physical, mental and emotional health. Initially, our primary focus will be relieving any issue that may have brought you into our door. Once the pain subsides and correction of your spine and nervous system starts to take place, you should begin to enjoy the benefits of improved health, vitality and quality of life. We pride ourselves on educating our patients in all aspects of achieving optimum health, and we welcome the opportunity to help you, your family and those you care about, all reach your individual goals.

Every day we all experience a variety of physical, biochemical, and emotional stresses that accumulate over time and, if not properly addressed, will result in a serious decrease in function and overall health. Please take the time to answer this form accurately and thoroughly, as it will give us a better understanding of any specific stresses affecting your health and allow us to better assess your current condition.

Welcome to Chiropractic Today!

Before we begin, what are your hopes & expectations as you begin chiropractic care?

❑ Temporary Pain/Symptom Relief ❑ Improved Function ❑ Increased Quality of Life ❑ Optimum Health/Wellness

Personal Information

Patient Name: ______________________________ Today's Date: ____ / ____ / ______

Age: ______ Birth date: ____ /____ /_______ Male ❑ Female ❑ SSN: _____-____-_______

Single ❑ Married ❑ Divorced ❑ Widowed ❑ Spouse's Name: ____________________ Age: _____

Children? No ❑ Yes ❑ #: _____ Names & Ages: ______________________________

Address: ______________________________ City: ________________ State: _____ Zip: ________

Home #: ________________ Cell #: ________________ Email: ______________________________

Occupation: ______________________________

Employer: ______________________________ Work #: ____________________

Emergency Contact: ______________________________ Relationship: ______________________________

Home #: ____________________ Cell #: ____________________ Work #: ____________________

ASSIGNMENT & RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage and assign coverage and assignment directly to Chiropractic Today. I understand that I am financially responsible for my balance as well as all fees and/or charges for services provided, regardless of insurance coverage or payments made. I hereby authorize the doctors to release all information necessary to secure payment of benefits, and provide this signature to be valid on all insurance submissions.

Signature of Patient/Guardian: ______________________________ Date: _____ / _____ / _______

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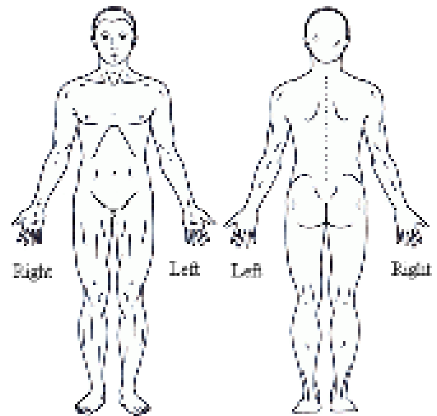
What brought you to our office?

You do not have to be experiencing any pain to enjoy the many benefits of chiropractic care. If you have no current symptoms or conditions and have come in as a patient to receive *Chiropractic Wellness Care*, please write "Wellness" on line #1 and then skip ahead to the section titled "General Health History."
For all others who are here for the initial treatment of your current health complaints, please briefly describe them below, along with how they are affecting your life.

	Health Complaints List your conditions according to severity	Intensity (1-10) 0 = no pain 10 = worst imaginable	Date the issue began?	Have you had this issue before?	Did the issue begin with an injury?
1.	______	______	______	Yes❑ No❑	Yes❑ No❑
2.	______	______	______	Yes❑ No❑	Yes❑ No❑
3.	______	______	______	Yes❑ No❑	Yes❑ No❑
4.	______	______	______	Yes❑ No❑	Yes❑ No❑

If you are experiencing pain, mark where on the diagram.



Since your pain began, it is now:
Getting Worse ❑ Getting Better ❑ About the Same ❑

Is this complaint interfering with your:
Work❑ Sleep❑ Exercise❑ Leisure❑ Mental Attitude❑
Other ❑: ______

Was this complaint due to an accident? Yes ❑ No ❑
If so, what type of accident? Auto ❑ Work ❑ Home ❑

Have you seen anyone else for this condition?
Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other ❑ ______

Doctor's Name: ______ Date seen: ______

What was done? ______

What was their diagnosis? ______ Were you satisfied with your care? Yes ❑ No ❑

Have you felt the need to, or been forced to make any positive changes in your life because of your current condition? (Examples: eat better, be more active, take supplements, more recreation, etc.)
If so, please explain: ______

______

______

______

______

General Health History

For each category below, please select any of the following stressors present in your current lifestyle

Physical Stressors	Biochemical Stressors	Emotional Stressors
❑ Accidents	❑ Alcohol	❑ Work/School
❑ Falls	❑ Tobacco	❑ Relationships
❑ Surgeries	❑ Prescription Drugs	❑ Finances
❑ Sports	❑ OTC Drugs	❑ Time Management
❑ Excessive Exercise	❑ Caffeine	❑ Grief
❑ Inactivity	❑ Processed Foods	❑ Worry
❑ Birth Trauma	❑ Unhealthy Diet	❑ Self-Esteem
❑ Excessive Sitting	❑ Dehydration	❑ Anger
❑ Excessive Standing	❑ Refined Sugar	❑ Depression
❑ Sedentary Lifestyle	❑ Environmental Toxins	❑ Fear

Other stressors: ____

On a scale from 1-10 with 10 being the best imaginable, please rate the following:

Overall Health = _____ Physical Health = _____ Emotional Health = _____

Eating Habits = _____ Exercise Habits = _____ Sleeping Habits = _____ Mindset = _____

Health Goals:

❑ More Energy	❑ Increased Function	❑ Lose ____ pounds	❑ Decreased Pain
❑ Exercise More	❑ Improve Nutrition	❑ Increased Fitness	❑ Greater Flexibility
❑ Sleep Better	❑ Reduced Stress	❑ Quality Relationships	❑ Positive Mental Attitude

Health is controlled by your nervous system, but it's affected by your environment and lifestyle habits.
Please answer below to give us an indication of your risk factors.

Social Risk Factors:			*Comments:*
Do you smoke?	Yes ❑	No ❑	______________
Do you drink alcohol?	Yes ❑	No ❑	______________
Do you have a healthy diet?	Yes ❑	No ❑	______________
Do you take nutrition supplements?	Yes ❑	No ❑	______________
Do you drink plenty of water?	Yes ❑	No ❑	______________
Do you consume caffeine?	Yes ❑	No ❑	______________
Do you exercise regularly?	Yes ❑	No ❑	______________
Do you sleep well?	Yes ❑	No ❑	______________
Is your job stressful?	Yes ❑	No ❑	______________
Is your family life stressful?	Yes ❑	No ❑	______________

Can you think of anything else that has a positive or negative effect on your health?
No ❑ Yes ❑: ____

Family Risk Factors:

Does anyone in your family have a history of any of the following?

❑Cancer ❑Stroke ❑Heart Disease ❑Diabetes ❑Hypertension ❑Autoimmune

Explain:

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Have You Ever Suffered From Any Of The Following?

- ❑ ADD/ADHD
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Alzheimer's
- ❑ Arm/Shoulder Pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Balance Issues
- ❑ Bladder Issues
- ❑ Bowel Issues
- ❑ Breathing Issues
- ❑ Bruising
- ❑ Cancer
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cholesterol Problems
- ❑ Circulatory Issues
- ❑ Cold Hands/Feet
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues
- ❑ Dizziness
- ❑ Ear Issues
- ❑ Eating Disorders
- ❑ Epilepsy
- ❑ Eye Problems
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever (prolonged)
- ❑ Fibromyalgia
- ❑ Fractured Bones
- ❑ Frequent Infections
- ❑ Gall Bladder Issues
- ❑ Gout
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Hip Pain
- ❑ Hypertension
- ❑ Insomnia
- ❑ Joint Pain
- ❑ Knee/Leg Pain
- ❑ Liver Issues
- ❑ Low Back Pain
- ❑ Measles
- ❑ Menstrual Problems
- ❑ Mid Back Pain
- ❑ Migraines
- ❑ Mononucleosis
- ❑ Mood Swings
- ❑ Muscle Cramps
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Neck Pain
- ❑ Nervousness
- ❑ Numbness/Tingling
- ❑ Osteoporosis
- ❑ Pregnancy Issues
- ❑ Pneumonia
- ❑ Prostate Issues
- ❑ Prosthesis
- ❑ Psychological Issues
- ❑ Rheumatoid Arthritis
- ❑ Sciatica
- ❑ Scoliosis
- ❑ Seizures
- ❑ Shingles
- ❑ Sinus Issues
- ❑ Skin Problems
- ❑ Stomach Issues
- ❑ Stoke
- ❑ Stress
- ❑ Tension
- ❑ Thyroid Issues
- ❑ TMJ Issues
- ❑ Uncoordinated
- ❑ Venereal Disease
- ❑ Vertigo

Check any medications you are currently taking:

- ❑ Blood Pressure
- ❑ Birth Control Pills
- ❑ Steroids
- ❑ Blood Thinners
- ❑ Depression/Anxiety
- ❑ Stimulants
- ❑ Pain Killers
- ❑ Muscle Relaxants
- ❑ Tylenol/Advil
- ❑ Antibiotics
- ❑ Hormones
- ❑ Others: ______________________

Chiropractic care is based on the clinical evidence of vertebral subluxations, which can be detected both in the presence and/or absence of pain. I authorize Chiropractic Today to administer my care as they deem appropriate based on objective examination and analysis, and not solely on my levels of discomfort. Included in my Chiropractic Wellness Care, I am responsible for attending at a minimum Health Care Class #1 that is presented free to me of charge as a service by the doctors at Chiropractic Today to help me better understand how my lifestyle choices affect my health.

I testify that all information provided in this form is accurate, and having completed this form and reading the above paragraph, I hereby consent to receive chiropractic care.

____ Signature

____ / ____ / ________ Today's Date

Thank you for taking the time to fill out this form. It is your first step to achieving wellness!
Present this to the front desk and you will begin shortly