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. However, Chiropractic Today is not your typical chiropractic office. 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 reach your individual goals.

Please take the time to answer this form accurately and thoroughly, as it will give us a better understanding of any stresses affecting your health and allow us to better assess your current condition.

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

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

Personal Information

Patient Name: ____ **Today's Date:** ___ / ___ / _____

How did you hear about us? ____

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 #:** ___________________

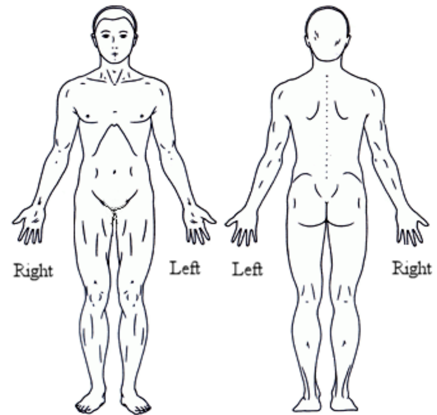
ASSIGNMENT & RELEASE: **I, the undersigned, certify that I (or my dependent) have insurance coverage and assign coverage and assignment directly to Chiropractic Today. I understand that I am financially responsible for my balance as well as all fees and/or charges for services provided, regardless of 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:** ____ / ____ / _____

Chiropractic Today
Total Natural Health

	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 ❑: ____________________________________

Taking any medication for the pain? _________________________

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 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 Attitude

. 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 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 ❑: ____

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

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

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Have You Ever Suffered From Any Of The Following?

Category 1:

- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Alzheimer's
- ❑ Arm/Shoulder Pain
- ❑ Balance Issues
- ❑ Depression
- ❑ Dizziness
- ❑ Ear Issues
- ❑ Epilepsy
- ❑ Eye Problems
- ❑ Fainting
- ❑ Headaches
- ❑ Insomnia
- ❑ Migraines
- ❑ Mood Swings
- ❑ Neck Pain
- ❑ Nervousness
- ❑ Psychological Issues
- ❑ Seizures
- ❑ Sinus Issues
- ❑ Skin Problems
- ❑ Thyroid Issues
- ❑ TMJ Issues
- ❑ Uncoordinated
- ❑ Vertigo

Category 2:

- ❑ Arthritis
- ❑ Asthma
- ❑ Breathing Issues
- ❑ Chest Pain
- ❑ Cholesterol Problems
- ❑ Circulatory Issues
- ❑ Cold Hands/Feet
- ❑ Diabetes
- ❑ Digestive Issues
- ❑ Fatigue
- ❑ Fever (prolonged)
- ❑ Fibromyalgia
- ❑ Frequent Infections
- ❑ Gall Bladder Issues
- ❑ Gout
- ❑ Heart Disease
- ❑ Liver Issues
- ❑ Mid Back Pain
- ❑ Mononucleosis
- ❑ Pneumonia
- ❑ Rheumatoid Arthritis
- ❑ Shingles
- ❑ Stomach Issues

Category 3:

- ❑ Back Pain
- ❑ Bladder Issues
- ❑ Bowel Issues
- ❑ Hernia
- ❑ Hip Pain
- ❑ Knee/Leg Pain
- ❑ Low Back Pain
- ❑ Menstrual Problems
- ❑ Pregnancy Issues
- ❑ Prostate Issues
- ❑ Sciatica
- ❑ Scoliosis

Category 4:

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Bruising
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Eating Disorders
- ❑ Fractured Bones
- ❑ Herniated Disc
- ❑ Hypertension
- ❑ Joint Pain
- ❑ Measles
- ❑ Muscle Cramps
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Numbness/Tingling
- ❑ Osteoporosis
- ❑ Prosthesis
- ❑ Stoke
- ❑ Stress
- ❑ Tension
- ❑ Venereal Disease

Check any medications you are currently taking:

- ❑ Blood Pressure
- ❑ Depression
- ❑ Anxiety
- ❑ Tylenol/Advil
- ❑ Birth Control
- ❑ Stimulants
- ❑ Antibiotics
- ❑ Steroids
- ❑ Pain Killers
- ❑ Hormones
- ❑ Blood Thinners
- ❑ Muscle Relaxer
- ❑ 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 of 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 ____ / ____ / _________