

PATIENT INFORMATION

Name: _____ Gender: M F

Home Address: _____ Apt: _____

City, State: _____ Zip: _____

Home/Cell Phone: () _____ Work Phone: () _____

Email Address: _____

Birth Date: ____/____/____ Social Security #: _____ - _____ - _____

Employer: _____ Occupation: _____

Marital Status: S M D W

Spouse's Name: _____ Work/Cell Phone: () _____

Occupation: _____

Do you have children? Y N

Emergency contact: _____ Phone #: _____

Who may we thank for referring you to our office?

Reason(s) for visit: _____

When did this start? ____/____/____ Episodic (on and off) Sudden Progressive

IDENTIFY SYMPTOMS

- Back Pain
 - Painful joints
 - Depression
 - Tension
 - Depression
 - Frequent colds/flu
 - Dizziness/Balance
 - Other _____
- Mood Swings
 - Headache
 - Sciatica
 - Ringing in ears
 - Urination problems
 - High/low blood pressure
 - Insomnia/sleep problems
- Low libido
 - Fatigue
 - Irritability
 - Ulcers
 - Pins and Needles
 - Menstrual Pain
 - Cold Hands/Feet
- Neck pain
 - Heartburn
 - Fevers/Chills
 - Low energy
 - Weight gain/loss
 - Constipation/Diarrhea
- Numbness/tingling
 - Loss of smell/taste
 - Light bothers eyes
 - Upset stomach
 - Nervousness/anxiety

List any medicatons _____

What activities aggravate your symptoms?

- Walking/running
 - Dancing
 - Watching TV
 - Rolling over
- Sitting
 - Sleeping
 - Lifting
 - Driving
- Bending
 - Computer work
 - Pushing
 - Other _____
- Concentrating
 - Playing sports
 - Reading

If experiencing spinal pain, please provide additional details below:

- Neck
- Upper back
- Mid back
- Lower back
- Other

Quality of pain:

- Sharp
- Dull
- Ache
- Burn
- Throb
- Spasm
- Numb
- Tingling
- Shooting

Does the pain radiate into your: Arm Leg Does not radiate

On a scale of 1-10, what's your level of pain when it's at its worst? _____

How often do you experience these symptoms throughout the day?

- 100%
- 75%
- 50%
- 25%
- 10%
- Only with Activity

Does complaint(s) interfere with: __ Work __ Sleep __ Hobbies __ Daily Routine

Have you suffered from this problem (or similar) in the past? Yes No

If yes, how often: _____ When was the last episode: _____

Have you tried other forms of treatment? Yes No

If yes, please state type of treatment: _____

Who provided treatment: _____ How long ago: _____

What were the results: Very favorable Favorable Neutral Unfavorable

Explain: _____

Have you been diagnosed with any of the following conditions:

Heart disease Depression Diabetes Immune/Auto-immune issues

Cancer Bone disease Thyroid problem Diabetes

Irritable Bowel Syndrome (IBS) Restless Leg Syndrome (RLS) Scoliosis

Other _____

Any additional conditions your doctor should be made aware of (medications, history, etc)?

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate that you have been made aware of its availability:

Initials _____

The Statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____ **Date:** _____

Guardian Signature _____ **Date:** _____

Regarding: Chiropractic Adjustments and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, may pose certain risks. While the risks are generally very minimal, in rare cases, complications, such as sprain/strain injuries, irritation of disc conditions, and although extremely rare, minor fractures.

Treatment objectives as well as possible risks associated with chiropractic adjustments and all other procedures provided at Palm Beach Health Center have been explained to my satisfaction, and I have conveyed my understand of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method and/or techniques that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature

___/___/___
Date

Witness Initials

Regarding: X-Rays/Imaging Studies

FEMALES ONLY: Please read carefully and check the two statements below, include the appropriate date, then sign below if you have no further questions. Otherwise, please see the front desk for further explanation.

_____ The first day of my menstrual cycle was ___/___/___
Initial Date

_____ I have been provided a full explanation of when I am most likely to become
Initial pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I acknowledge that the doctor and or a member of this staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, therefore, I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature

___/___/___
Date

Witness Initials