IDEAL CHIROPRACTIC HEALTH CENTER

WELCOME

PERSONAL INFORMATION

Patient Name: _____Preferred Name: _____

Birthdate: _____/ _____ /_____Age: _____ □ Male □ Female Weight: _____lbs. Height: _____Ft. _____In.

Mailing Address: _____City: _____State: _____Zip:_____

Primary Contact Number:_____ Email:_____

Referred By: _____

Employer: _____Occupation: _____

What pregnancy is this for you? ☐1st ☐ 2nd ☐3rd ☐4th What is your due date?_____

Who is your (circle all that apply) midwife, OB/GYN, or doula? Name(s): _____

Phone number(s): (___)_____ Phone number(s): (___)_____

Text Reminders: You will receive a text four hours before your reserved appointment.

REASON FOR VISIT

What is your primary pain/complaint? _____

_____

Describe the quality of your primary pain/compliant, is it (circle any that apply): burning, crushing, dull, sharp, tearing, or tingling?

*Is there any pattern to the quality of your pain, such as (circle all that apply): constant, intermittent, or throbbing?

*On a scale of 0-10, with 10 being the greatest pain, what is your pain rating when you are suffering (circle a number):0 1 2 3 4 5 6 7 8 9 10?

What date did you first notice your primary pain/complaint? _____

_____

Did something cause your primary pain/complaint to begin? _____

_____

If you saw any doctor or health care practitioner for your primary pain/compliant, please list their names and what they did, or prescribed, for you:

Doctor/Health Practitioner's Name:	What they did, or prescribed, for you:

Do you have a significant other or are you married? (Circle an answer): Yes No? If yes, please list their name and relationship to you. _____

Do you have any children (Circle an answer): Yes No? If yes, please list their name(s) and age(s)?

Name(s):	Age(s):

HEALTH HISTORY

Are you experiencing any of the following? □ None

□ Headaches	□ Arm/Leg Pain	□ Digestive Issues	□ Fatigue
□ Neck Pain	□ Leg/Foot Pain	□ Anxiety	□ Nausea/Vomiting
□ Back Pain	□ Difficulty Sleeping	□ Depression	□ Gestational Diabetes

Are you taking any of the following medications?

□ Nerve Pills	□ Pain Killers (Including Aspirin)	□ Muscle Relaxers	□ None
□ Blood Thinners	□ Stimulants	□ Insulin	□ Other (s)

Do you have or ever had any of the following conditions? (Please check all that apply.) □ None

□ Heart Attack	□ Heart Surgery/Pacemaker	□ Heart Murmur	□ Congenital Heart Defect
□ Mitral Valve Prolapse	□ Artificial Valves	□ Alcohol/Drug Abuse	□ Venereal Disease
□ Hepatitis	□ HIV+/AIDS	□ Shingles	□ Cancer
□ Frequent Neck Pain	□ Emphysema/Glaucoma	□ Anemia	□ High/Low Blood Pressure
□ Psychiatric Problems	□ Rheumatic Fever	□ Severe/Frequent Headaches	□ Kidney Problems
□ Ulcers/Colitis	□ Fainting/Seizures/Epilepsy	□ Sinus Problems	□ Asthma
□ Diabetes/Tuberculosis	□ Difficulty Breathing	□ Chemotherapy	□ Lower Back Problems
□ Artificial Bones/Joints	□ Arthritis	□ Constipation	□ Diarrhea

Please list any other serious medical conditions your child has or ever had: _____
_____

The Birth Process:

The birth process can injure a baby's spine and cause damage to their delicate Nervous system. Research is showing that many of the health challenges that occur later in life have their origins during the development years, some starting at birth.

Please note your experience with a previous pregnancy (if this is your first pregnancy, please skip).

Location:	**Intervention:**	**Labor, Delivery & Afterbirth**
□ Home	□ Caesarian Section	□ Creech Presentation
□ Natural Birth Center	□ Episiotomy	□ Transverse Lie
□ Hospital	□ Forceps Delivery	□ Post-Partum Depression
	□ Vacuum Extraction	□ Difficulty Breastfeeding
	□ Induced Labor	□ Other: _____
	□ Epidural	

Previous Injuries, Surgeries, Hospitalizations: **Injuries include car accidents, athletic injuries.*

Date:	Type:	Treatment & Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL Current Medications: (Prescription and over-the-counter)

Name & Dosage:	Reason for taking:
_____	_____
_____	_____
_____	_____

Please List ALL Current Supplements:

Name & Dosage:	Reason for taking:
_____	_____
_____	_____
_____	_____

*continued on next page

CONSENT TO CHIROPRACTIC CARE

- You are invited to discuss, with staff, any questions regarding services in the office. The best health services are based on friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office.)
- I hereby authorize the Dr.'s of Ideal Chiropractic Health Center and whomever he may designate as his assistants to examine and administer chiropractic care as he so deems necessary to the person listed below,
  (Patient's name) _____

Signature: _____ Date: _____