



Name: \_\_\_\_\_ Date: \_\_\_\_\_

## OUR MISSION STATEMENT

To be able to help as many people as we can, reach their potential, especially children

We are encouraging all our patients to help us in this most important and noble mission.

## Patient Introduction

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. THANK YOU.

**Personal History:**

Your Name: \_\_\_\_\_ Age \_\_\_\_\_  
                                     First                                    Middle                                    Last

Child's Name (if the patient): \_\_\_\_\_  
   First                                    Middle                                    Last

Address: \_\_\_\_\_  
                                     \_\_\_\_\_  
                                     \_\_\_\_\_

Last four of SS# \_\_\_\_\_

Cell#: \_\_\_\_\_ Bus#: \_\_\_\_\_ Cell Service Provider: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Ph/Cell# \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

City: \_\_\_\_\_

Last visit to this Chiropractor: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_  
                                     \_\_\_\_\_  
                                     \_\_\_\_\_

Present MD: \_\_\_\_\_ PH#: \_\_\_\_\_

City: \_\_\_\_\_

Referred to our Center by: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## Our Fee Structure

**Please note our fees for your initial visit:**

<b>Consultation</b>	Complimentary
<b>Examination</b>	\$ 50.00
<b>SEMG &amp; Thermography</b>	\$ 30.00
<b><u>Radiology</u></b>	<u>\$ 100.00</u>
<b>TOTAL</b>	<b>\$ 180.00</b>

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Our policy for **missed appointments** is simple. We recognize that things happen, please inform us of any possible absences prior to your scheduled time by calling the office. There is a service charge of \$45 for missed appointments if you do not call, and let us know. Our missed appointment charges are donated to the International Chiropractic Pediatric Association in Pennsylvania for pediatric research.

(INITIAL) \_\_\_\_\_

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Signature of Parent/Guardian required if patient under age 18)

***Thank You!***



## Adult Consultation History

**What Are Your Main Complaint(s):** \_\_\_\_\_

\_\_\_\_\_

How long have you suffered with this problem? \_\_\_\_\_

List all that you have tried to do to get rid of these problems that **DID NOT** work? \_\_\_\_\_

\_\_\_\_\_

Have you become discouraged about handling this problem? YES \_\_\_\_\_ NO \_\_\_\_\_

When your problem is at its worst, how does it make you feel? \_\_\_\_\_

\_\_\_\_\_

We want to help improve your quality of life. Tell us how the following areas of your life are affected?

WORK: \_\_\_\_\_

FAMILY: \_\_\_\_\_

HOBBIES: \_\_\_\_\_

LIFE: \_\_\_\_\_

Does handling this problem cause stress for you? \_\_\_\_\_

What do you do that makes this problem worse? \_\_\_\_\_

How much older does this issue you feel? \_\_\_\_\_

**On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us SOLVE this problem:** \_\_\_\_\_

What gives you some temporary relief? \_\_\_\_\_

What is the pattern of this problem?

Constant \_\_\_\_, Intermittent \_\_\_\_, Occasional \_\_\_\_, Cyclic \_\_\_\_

What is the effect it has on your body functions? \_\_\_\_\_

How did it start? \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Are you on any type of medication? \_\_\_\_\_, Please list all: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Could your problem have been caused by an injury at work? \_\_\_\_\_

If yes, please give us the details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been involved in any accident(s), falls or fights? YES \_\_\_\_\_ NO \_\_\_\_\_  
Date of accident(s): \_\_\_\_\_

Any health issues left-over from these accidents? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any children? \_\_\_\_\_

Do they have any health problems that you are aware of? \_\_\_\_\_  
\_\_\_\_\_

Is there any other information you would like us to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Women Only**

Date of your last menstrual period: \_\_\_\_\_

Are using any means of contraception? \_\_\_\_\_

Do you experience severe cramping with your menstrual period? \_\_\_\_\_

Do they last more than 5 days? \_\_\_\_\_ How long? \_\_\_\_\_

Do you suffer from PMS? \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## Special Summary Questions

**List the 5 problems you want to get rid of, or your five goals that you would like to achieve.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**List everyone you have seen and what you have tried to do to get rid of these problems or reach these goals.**

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**Write down the things you are willing to do to get rid of your problem or reach your goals.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Tell me what you would do that you haven't been able to do, after your problems are gone and you have reached your goals.**

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SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## FAMILY HEALTH HISTORY

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation "C" under his or her column. The designation "P" should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Thank you!