Name:_____ Birthdate:_____ Age_____

Gender: M F Gender at birth: M F

Name of primary physician: _____ Phone number: _____

Reason for visit: _____

Have you had similar conditions in the past? _____

Is your visit related to any of the following: Motor vehicle accident Work injury Other injury

Has your case been referred to an attorney? Y or N

Have you been treated by anyone for this condition? Who? _____

Have you ever been treated by a chiropractor, acupuncturist or other holistic practitioner? Y or N

Have you recently been under the care of a medical doctor? When and for what condition? _____

_____

List any medications you are taking or have taken for extended periods: _____

_____

Confidential Health Information Form

If you need any assistance filling out this paperwork, please ask. It is our pleasure to help.

List surgeries, injuries, and accidents	Dates of incidents	If additional space is needed,
_____	_____	check here ☐ and use the
_____	_____	back of this sheet
_____	_____	
_____	_____	

List allergies (food, drugs, animals, environment, etc): _____

CONSENT TO ROUTINE CHIROPRACTIC SERVICES: I consent to the services to be rendered during this visit on an outpatient basis by Alex Craig, DC, and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above. I understand and am informed that in the practice of chiropractic there are some risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____ _____

Client/Patient signature ***Date***

_____ _____

Print name ***Client/ Patient name – if signing as a parent or legal guardian***

(Name) (Date of Birth) (Age) (Today's Date)

Personal Health History

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you.
Please check all conditions you currently have or have had. To be responsible for your case, we need your complete health history.☐

General

☐ Sweats ☐Chills ☐Convulsions ☐Dizziness ☐Fainting
☐Fatigue ☐Fever ☐Headache ☐Loss of Sleep ☐Loss of Weight
☐Neuralgia ☐Tremors ☐Numbness ☐Anxiety, Depression

Muscular / Joint

☐Arthritis ☐Bursitis ☐Foot Trouble ☐Neck Pain or Stiffness ☐Multiple sclerosis
☐Low Back Pain ☐Lumbago ☐Hernia ☐TMJ pain Pain btwn Shoulders

Skin

☐Bruise Easily ☐Cold sores ☐Dryness ☐Itching ☐☐Eczema
☐Rash or Hives ☐Skin problems ☐Slow wound healing ☐Varicose Veins

Cardiovascular/ Respiratory

☐Artery hardening ☐Blood clots ☐Chest pain ☐Hypertension ☐Poor circulation
☐Rapid heartbeat ☐Arrhythmia ☐Swelling ☐Chronic Cough ☐Breathing difficulty
☐Spitting up blood ☐Wheezing ☐Asthma ☐Emphysema

Eye, ear, nose, and throat

☐Allergies ☐ ☐Cold/ flu often ☐Dental decay ☐Double Vision ☐Ear Problem
☐Enlarged Glands ☐Enlarged Thyroid ☐Eye Pain ☐Nose Bleeds ☐ Hearing Changes ☐
☐Sinus Infection ☐Hoarseness ☐Sore Throat ☐Swallowing Pain ☐Vision Changes

Genitourinary

☐Blood/ Pus in urine ☐Frequent Urination ☐Incontinence ☐Kidney Infections
☐Prostate Problems ☐ ☐Lack of Control ☐Urinary Urgency ☐ ☐Painful Urination

Gastrointestinal

☐Belching / Gas ☐Bloated abdomen ☐Colon Trouble ☐Hemorrhoids ☐Constipation/ Diarrhea
☐Difficult Digestion ☐Loss of Appetite ☐Gallbladder/ Liver ☐Nausea/ Vomiting ☐Parasites/ Worms

Women Only

ARE YOU PREGNANT? ☐No ☐Yes DUE DATE _____ # OF CHILDREN_____
☐Painful Breasts ☐Menstrual issues ☐Hot Flashes ☐Irregular Cycle ☐Menopause

Is your lifestyle or diet currently unbalanced with any of the following?

☐Alcohol ☐Artificial sugars ☐Coffee ☐Drugs ☐Exercise ☐Salty foods
☐Sleep ☐Soft drinks ☐Stress ☐Water ☐Tobacco ☐Sugar products

Have you ever had

☐Alcoholism ☐Anemia ☐Arteriosclerosis ☐Arthritis ☐Whiplash
☐Blood disorder ☐Cancer ☐Chicken pox ☐Diabetes ☐Pneumonia
☐Gout ☐Heart disease ☐Hepatitis ☐Herpes ☐Ulcers
☐Hypoglycemia ☐ ☐Hypertension – high ☐Implant ☐Kidney disease ☐Tuberculosis
☐Measles ☐Hypotension – low ☐Mental illness ☐Miscarriage ☐Obesity
☐Pacemaker ☐Prosthesis ☐Pleurisy ☐Seizure disorder ☐Stroke

Do any immediate family (parents, grandparents, siblings) have or ever had:

☐Alcoholism ☐Arthritis ☐Blood disorders ☐Cancer ☐Diabetes
☐Heart disease ☐Hypertension ☐Kidney disease ☐Mental illness ☐Seizure disorder
☐Stroke ☐Other hereditary condition: _____

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