TotalHealth
CHIROPRACTIC CENTER

It's your future... Be there healthy!

PERSONAL INFORMATION

First Name:_____ Last Name: _____ MI_____ Date: _____

Address: _____City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W Spouses Name: _____ # of Children: _____

Occupation: _____ Employer's Name: _____

Work Address: _____ City/State/Zip: _____

How were you referred to our office?: ☐ Google ☐ Drive By ☐ Social Media

☐ Friend _____ ☐ Other_____

Do you Have a Primary Care Physician? ☐ Yes ☐ No Name: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Have you ever seen a Chiropractor Before? ☐ Yes ☐ No If Yes, When: _____

Where: _____ Results:_____

MAJOR COMPLAINT INFORMATION

What is/are your complaint(s)?: _____

_____

When did these symptoms begin?: _____ Has this condition existed in the past?: ☐ Yes ☐ No

These symptoms were a result of: ☐ Auto Accident ☐ Work Injury ☐ Other _____

Is this condition getting progressively Worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes

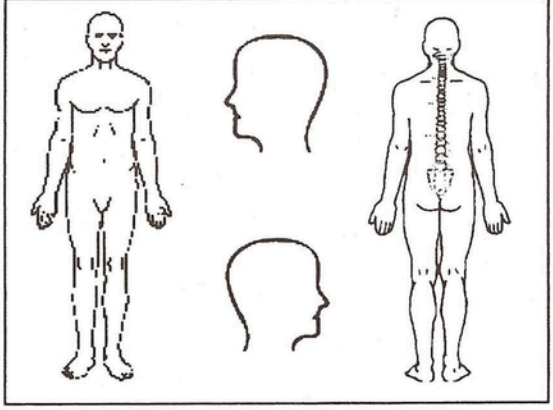
Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

How long has it been since you felt good?: _____

List other doctors who have treated this condition: _____

Have you been in an auto accident: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Please mark your areas of pain on the figures below:



If this is an injury, please describe what happened.

_____

_____

_____

_____

_____

_____

CHECK THOSE ACTIVITIES BELOW DURING WHICH YOU EXPERIENCE DIFFICULTY OR PAIN

- ☐ Lying on back
- ☐ Lying on side with knees bent
- ☐ Turning over in bed
- ☐ Walking
- ☐ Getting in/out of car
- ☐ Gripping
- ☐ Climbing
- ☐ Dressing self
- ☐ Lying flat on stomach
- ☐ Pushing
- ☐ Pulling
- ☐ Reaching
- ☐ Stooping
- ☐ Sitting
- ☐ Bending forward
- ☐ Bending backward
- ☐ Standing for periods over one hour
- ☐ Sneezing
- ☐ Coughing
- ☐ Other: _____

HABITS

- ☐ Smoking — Packs/Day: _____
- ☐ Alcohol — Drinks/Day: _____
- ☐ Coffee — Cups/Day: _____
- ☐ Soft Drinks — Drinks/Day: _____
- ☐ Water — Glasses/Day: _____
- ☐ Vitamins — List:

EXERCISE

- ☐ None
- ☐ 1-2 days/week
- ☐ 3-4 days/week
- ☐ 5+ days/week

Type _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Primary Insurance Info:

Insurance Company: _____ Policy Holder's Name: _____

Relation to Patient _____ Policy Holders' S.S. Number: _____

Policy Number: _____

Insured Place of Employment: _____

Do you have a Secondary Policy? ☐ Yes ☐ No

Insurance Company: _____ Policy Holder's Name: _____

Relation to Patient _____ Policy Holders' S.S. Number: _____

Policy Number: _____

Insured Place of Employment: _____

FAMILY HISTORY

Please √ all that apply

	Stroke	Bad Posture	Heart Trouble	High Blood	Cancer	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Diabetes
Father																
Mother																
Brother																
Sister																
Child																
Child																
Child																

CHECK THE FOLLOWING CONDITIONS AS THEY APPLY TO YOU

Never	Previously	Presently	GENERAL SYMPTOMS/ CONDITIONS
☐	☐	☐	Migraines
☐	☐	☐	Allergy (what) _____
☐	☐	☐	Bronchitis
☐	☐	☐	Chills (Constant)
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Headache
☐	☐	☐	Loss of Sleep
☐	☐	☐	Loss of Weight
☐	☐	☐	Nervousness
☐	☐	☐	Night Sweats
☐	☐	☐	Numbness or Pain in arms/legs/hands
☐	☐	☐	Wheezing
☐	☐	☐	Polio
☐	☐	☐	Alcoholism
☐	☐	☐	Anemia
☐	☐	☐	Chicken Pox
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Pleurisy
☐	☐	☐	Arthritis
☐	☐	☐	Mumps
☐	☐	☐	Cancer
☐	☐	☐	Tuberculosis
☐	☐	☐	Venereal Disease
☐	☐	☐	HIV Positive
☐	☐	☐	Diabetes
☐	☐	☐	Measles
☐	☐	☐	Serious Injury
☐	☐	☐	_____other
☐	☐	☐	_____other

Never	Previously	Presently	GASTRO-INTESTINAL
☐	☐	☐	Belching or Gas
☐	☐	☐	Acid Reflux
☐	☐	☐	Heart Burn
☐	☐	☐	Colon Trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Gall Bladder Trouble
☐	☐	☐	Hemorrhoids (piles)
☐	☐	☐	Jaundice
☐	☐	☐	Liver Trouble
☐	☐	☐	Nausea
☐	☐	☐	Stomach Pain
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting Blood
☐	☐	☐	Bloody Stool
☐	☐	☐	Irritable Bowel
☐	☐	☐	Ulcers

CARDIO-VASCULAR

☐	☐	☐	High Blood Pressure
☐	☐	☐	Strokes
☐	☐	☐	Low Blood Pressure
☐	☐	☐	Chest Pain
☐	☐	☐	Heart Trouble
☐	☐	☐	Poor Circulation
☐	☐	☐	Rapid Heart
☐	☐	☐	Slow Heart
☐	☐	☐	Swollen Ankles
☐	☐	☐	Varicose Veins
☐	☐	☐	Pacemaker

Never	Previously	Presently	EYE/EAR/ NOSE/THROAT
☐	☐	☐	Sinusitis
☐	☐	☐	Asthma
☐	☐	☐	Deafness
☐	☐	☐	Earache
☐	☐	☐	Ear Discharge
☐	☐	☐	Ear Noises
☐	☐	☐	Thyroid Problems
☐	☐	☐	Frequent Colds
☐	☐	☐	Hay Fever
☐	☐	☐	Nasal Obstruction
☐	☐	☐	Nose Bleeds
☐	☐	☐	Pain in Eyes
☐	☐	☐	Poor Vision
☐	☐	☐	Blurred Vision
☐	☐	☐	Sore Throats
☐	☐	☐	Tonsillitis

MUSCLES & JOINTS

☐	☐	☐	Backache
☐	☐	☐	Pain Between Shoulders
☐	☐	☐	Stiff Neck
☐	☐	☐	Foot Trouble
☐	☐	☐	Hernia
☐	☐	☐	Painful Tail Bone
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen Joints
☐	☐	☐	Tremors
☐	☐	☐	Twitching
☐	☐	☐	Spinal Disc Disease
☐	☐	☐	Dislocated Joints

Never	Previously	Presently	RESPIRATORY
☐	☐	☐	Chest Pain
☐	☐	☐	Chronic Cough
☐	☐	☐	Difficulty Breathing
☐	☐	☐	Spitting Blood
☐	☐	☐	Spitting Phlegm

GENITO-URINARY

☐	☐	☐	Bed Wetting
☐	☐	☐	Blood in Urine
☐	☐	☐	Frequent Urination
☐	☐	☐	Inability to Control Urine
☐	☐	☐	Kidney Infections
☐	☐	☐	Kidney Stones
☐	☐	☐	Painful Urination
☐	☐	☐	Prostate Trouble

NEUROLOGICAL

☐	☐	☐	Anxiety
☐	☐	☐	Mood Swings
☐	☐	☐	Phobias
☐	☐	☐	Mental Disorders
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Epilepsy
☐	☐	☐	Memory Loss or Impairment
☐	☐	☐	Depression

FOR FEMALES ONLY

☐	☐	☐	Irregular Cycle
☐	☐	☐	Cramps
☐	☐	☐	Hot Flashes
☐	☐	☐	Painful Periods

☐ Yes ☐ No **Pregnant at this time?**

_____Last Menstrual Cycle

ADDITIONAL INFORMATION

List all medications you are taking now, including over the counter medication: _____

_____

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No

If so, please list: _____

_____

Any additional information you would like the doctor to know about before beginning care at Total Health Chiropractic Center? _____

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Total Health Chiropractic Center. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Total Health Chiropractic Center responsible for any errors or omissions that I may have made in the completion of this form

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Total Health Chiropractic Center to treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of _____ to _____.

Signature of Patient: _____ Date: _____

Signature of Staff: _____ Date: _____

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he may designate as assistance to administer chiropractic care as he deems necessary to my _____(indicate relationship to child).

Name of Child: _____ Date: _____

Signature of Parent or Guardian: _____

Signature of Staff: _____ Date: _____