Welcome to our office. Please complete this form to tell us how we can help you today.

firstchiropracticcenter.com

Patient Number ________
(office use only)

Today's Date: ___________

Have you consulted a chiropractor before? ○ No ○ Yes

____
Whom may we thank for referring you?

When? ___________ If so, Whom? _________________

First Name	MI	Last Name	Birthdate	Age	Gender ○M ○ F

Address	City	State	Zip

Cell Phone	Home Phone	Work Phone	Social Security #

E-mail Address	Employer

Marital Status ○ Single ○ Married ○ Widowed ○ Other	Spouse Name	#of Children	Ages ○ 0-5 ○ 5-10 ○10-18 ○ Adult

Primary Language ○ English ○ Spanish ○ Other	Race ○ White ○ Hispanic ○ African American ○ Native American ○ Other	Ethnicity ○ Hispanic or Latino ○ NOT Hispanic or Latino	Tobacco Use ○ Smoke ○ Chew ○ None	Preferred Communication ○ Cell Phone ○ Home Phone ○ Work Phone ○ E-mail

Emergency Contact	Emergency Contact's Phone	Primary Physician

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):______________________**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy at any time.**

Initials _____ **I authorize my insurance company or administrator to pay First Chiropractic Centers, PC directly for the Benefits otherwise payable to me under my current policy**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____ ________________________
Signature Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: ____

Patient Number ________
(office use only)

first chiropractic CENTERS P.C.

____
Patient Name

I am interested in: ○Chiropractic Care ○Stretches and Exercise ○ Nutritional Advice ○ Acupuncture ○ Wellness Care ○ Quit Smoking

1. Onset (When did you first notice your current symptoms?)

____

2. Mechanism (How did this start?)

____

3. Intensity (How extreme are your current symptoms?) Please mark below

0○-○-○-○-○-○-○-○-○-○-○**10**

Absent Uncomfortable Unbearable

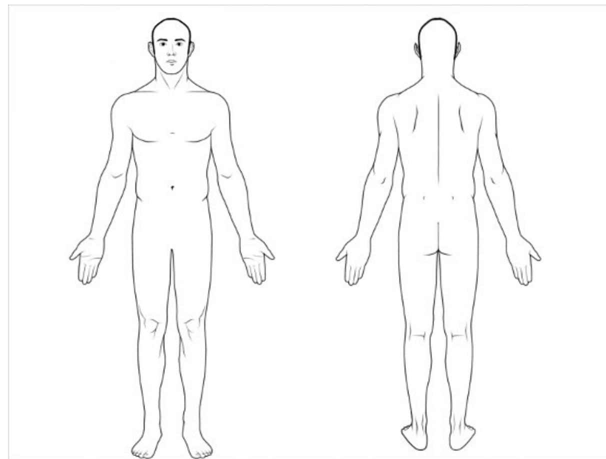
4. Duration and Timing

○ Constant
○ Comes and Goes

5. Quality of Symptoms
(What does it feel like?)

○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other__________________

6. Location Where does it hurt?
(Circle the area(s)on the illustration)



7. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

____

8. Prior Interventions (What have you done to relieve the symptoms?)

○Prescription Medication ○Surgery
○Over-the-Counter drugs ○Acupuncture
○ Physical Therapy ○Chiropractic
○Massage ○Heat ○Ice
○Other ______________________________

9.Aggravating or Relieving Factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?____

What tends to lessen the problem?____

10. How does your condition interfere with your:

Work_______________________________________ Recreational Activities_______________________

Household___________________________________ Personal Relationships______________________

11. What else should the doctor know about your current condition?

____

Consultation Notes

Vitals: (completed by staff)

H: ___________
W:___________
BP:___________
T:___________
P:___________
BMI:__________

____
Doctor's Initials