File # _____

Welcome to Chiropractic USA!

Our purpose is to educate and adjust as many families as possible towards optimal health through natural CHIROPRACTIC CARE !

CONFIDENTIAL PATIENT INFORMATION

Name_____ Date_____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone_____
Birth Date _____ Email Address _____
Age: _____ Marital Status: **S**ingle **M**arried **S**eparated **W**idow **D**ivorced

Children: Name:_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____

How were you referred to our office?_____
TV Radio Screening Friend Flyer Ad Physician

Employer_____ Occupation _____
Address _____ Telephone _____

Spouse's Name_____ Occupation_____
Employer_____ Telephone _____

Females: Are you pregnant? YES NO NOT SURE

PAYMENT IS EXPECTED AT TIME OF VISIT
Name of person responsible for payment : _____
Are you insured? NO Medicare MassHealth BCBS Other_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic USA 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 Chiropractic USA will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I understand that the fee paid for treatment X-rays is the cost of taking and reading the films. The film itself is the property of this office. Copies of these films (on CD) or any other records can be released with advanced request (usually 24 hrs.) and signed release.

Patient's Signature : _____ Date : _____

Patient Health History

Name:_____

File # _____ Date_____

The vast majority of our patients have been involved in dozens of IMPACTS that could cause **VERTEBRAL SUBLUXATION** (spinal misalignment). The doctor wants to discover **5** of yours.

♦Whether you felt injured or not, please list all automobile/motorcycle accidents…

Motor Vehicle Accident Date	Speed	Location of Impact	Any treatment?	Chiropractic care?
		Front, Side or Rear?	Yes or No	Yes or No
		Front, Side or Rear?	Yes or No	Yes or No
		Front, Side or Rear?	Yes or No	Yes or No
		Front, Side or Rear?	Yes or No	Yes or No
		Front, Side or Rear?	Yes or No	Yes or No

♦Most people have had a slip, strain, or fall at home, work or playing sports, whether it was reported or not. Please list these traumas whether you felt injured or not…

Circle or list type of trauma	Date	Briefly describe trauma/surgery	Any treatment?	Chiropractic care?
Slip, fall, strain, broken bone, surgery or illness?			Yes or No	Yes or No
Slip, fall, strain, broken bone, surgery or illness?			Yes or No	Yes or No
Slip, fall, strain, broken bone, surgery or illness?			Yes or No	Yes or No
Other:			Yes or No	Yes or No
Other:_____			Yes or No	Yes or No

Have you ever fallen while:

1. Learning to crawl or walk? Yes or No
2. Riding a bike, rollerskating/blading, playing…? Yes or No

Does it make sense how **VERTEBRAL SUBLUXATIONS** (spinal misalignments) are caused? Vertebral subluxation affects your ***nervous system***, which affects your ***health***.

Please list the names of other chiropractors that have treated you ?

_____ Date _____

_____ Date _____

Reasons for Consulting our Office

Name:_____
File# _____
Date_____

- ☐ I have no specific health problem. This is a general checkup.
- ☐ I have a symptom or complaint.

Chief complaint: _____

When did your complaint appear? _____

Rate the severity (circle your level) 0 1 2 3 4 5 6 7 8 9 10

None Medium Severe

Describe (check all that apply):

☐ sharp ☐ burning ☐ achy ☐ throbbing ☐ dull
☐ stabbing ☐ shooting ☐ stiff ☐ tingling ☐ other:_____

How often do you have your chief complaint?_____

Is it constant or occasional? _____

What makes it worse?_____

What makes it better?_____

What have you done for this? _____

What surgeries have you had? _____

What medications do you take?_____

_____

Have you experienced or are you experiencing? (check all that apply)

- ☐ Neck pain / stiffness
- ☐ Headaches / migraines
- ☐ Shoulder pain
- ☐ Arm / hand pain
- ☐ Upper / mid back pain
- ☐ Low back pain
- ☐ Leg pain
- ☐ Hip / groin pain
- ☐ High blood Pressure
- ☐ Stress
- ☐ Depression
- ☐ Allergies
- ☐ Asthma
- ☐ High cholesterol
- ☐ Dizziness
- ☐ other ? _____

Do you smoke ? NO YES How many per day? _____

Goal Question: If you could accomplish one important thing or mission for your life, what would that be?

_____

_____

_____

_____

Patient Signature: _____

Thank you for taking the time to fill out this form as completely and accurately as possible. This information is crucial to your case and the doctor will be reviewing it very carefully and correlating this information with your X-ray findings.
We look forward to helping you and your family toward optimal health.