CAMP VERDE FAMILY CHIROPRACTIC AND WELLNESS CENTER

Date: _____ How did you hear about us? _____

By taking your time and filling out the information to the best of your ability, you will give the doctor a better understanding of your current condition and he will be able to determine the best possible course of care for you as an individual. All information is strictly CONFIDENTIAL. We thank you for your patience and cooperation.

Patient Data

First Name_____ M.I._____ Last Name_____ *Email _____

Mailing address _____ City _____ State ____ Zip Code _____

Phone cell/home _____* cell service provider (ex: Verizon, needed for text appointment reminders) _____

Age _____ Birth Date _____/_____/_____ ☐ Male ☐ Female ☐Single ☐Married ☐ Widowed ☐Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Rather not answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Rather not answer Preferred Language: ☐English ☐ Other: Please list _____

Occupation _____ Employer _____Average hours worked per week: _____

Emergency Contact _____ Phone # _____ Relationship _____

Medical Doctor and name of practice _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name _____ Date of Last Adjustment _____

Reason for Previous Chiropractic Care _____

Present Condition

Reason for this visit _____

When and how did your present condition start?

_____

Is your condition the result of a: ☐ car accident ☐work injury

Have you had this condition before? ☐ Yes ☐ No

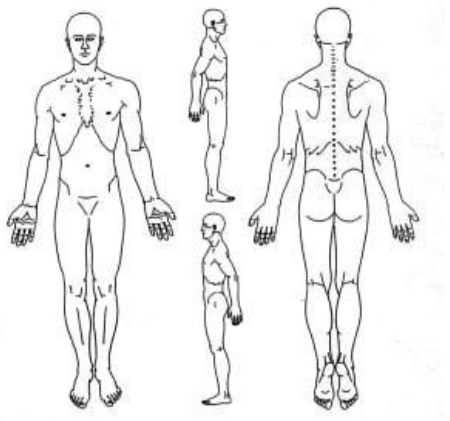
If so, when? _____

Intensity of your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

My condition improves when I… _____

My condition worsens when I… _____

Please indicate where you have pain or other symptoms



Describe your pain. Please select all that apply:

☐ Achy ☐ Radiating ☐ Stabbing ☐ Constant (76%-100% of the day)

☐ Burning ☐ Sharp ☐ Stiffness ☐ Frequent (51%-75% of the day)

☐ Dull ☐ Shooting ☐ Tingling ☐ Intermittent (26%-50% of the day)

☐ Numbness ☐ Soreness ☐ Occasional (0%-25% of the day)

☐ Other: _____

This condition prevents/interferes with my: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please explain how: _____

Activities/movements that are painful/difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Running ☐ Bending Over ☐ Lying Down ☐ Getting out of bed

☐ Other: _____

Who have you seen for your present condition?

☐ Nobody else ☐ Chiropractor ☐ MD ☐ Physical Therapist ☐ Surgeon ☐ Neurologist

☐ Other: _____

What treatments/tests were performed: (X-rays, MRI's): _____

Are you currently taking medication for your present condition? ☐ Yes ☐ No

If yes please list: _____

Past Health History

Have you ever had any surgery? ☐ Yes ☐ No

Please describe: _____

Have you ever been involved in any car accidents? ☐ Yes ☐ No

Please describe including any injuries: _____

Have you ever had and sports injuries, serious falls, broken bones? ☐ Yes ☐ No

Please describe: _____

Are you currently on or have you in the past year taken any prescription medications? ☐ Yes ☐ No

Please list: _____

Do you have any medication allergies? ☐ Yes ☐ No Please list: _____

Do you take any vitamins/minerals/herbs? ☐ Yes ☐ No

Please list: _____

Do you smoke? ☐ Yes ☐ No (☐ Former Smoker) ☐ Daily Smoker ☐ Non-Daily Smoker: # of packs per day: ___

Do you consume alcohol? ☐ Yes ☐ No # of drinks per week: _____

Do you use any recreational drugs? ☐ Yes ☐ No _____

Do you exercise? ☐ No ☐ Infrequently ☐ Occasionally ☐ Frequently ☐ Regularly

Women only: Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Anticipated due date: _____

Please review the following list and mark all that you *currently have or have had in the past*: (in addition please *circle all current conditions*)

☐	AIDS/HIV	☐	Cramps	☐	Insomnia	☐	Poor Circulation
☐	Alcoholism	☐	Diabetes	☐	Irregular Cycle	☐	Prostate Problems
☐	Allergies	☐	Digestive Problems	☐	Irregular Heart Beat	☐	Rheumatoid Arthritis
☐	Anemia	☐	Dizziness/Vertigo	☐	Kidney Infection	☐	Sciatica
☐	Anxiety/Depression	☐	Ear Ringing	☐	Kidney Stones	☐	Scoliosis
☐	Arm/Shoulder Pain	☐	Earache	☐	Leg Pain	☐	Shingles
☐	Arteriosclerosis	☐	Epilepsy	☐	Loss of Memory	☐	Shortness of Breath
☐	Arthritis	☐	Eye Pain/Difficulties	☐	Loss of Balance	☐	Sinus Infection
☐	Asthma	☐	Frequent Urination	☐	Loss of Smell	☐	Stroke
☐	Breast Lump	☐	Headache	☐	Loss of Taste	☐	Swelling of Ankles
☐	Bronchitis	☐	Headache – Migraine	☐	Low Back Pain	☐	Thyroid Condition
☐	Bruise Easily	☐	Hearing Disturbance	☐	Mid Back Pain	☐	TMJ Syndrome
☐	Cancer	☐	Heart Disease	☐	Neck Pain/Stiffness	☐	Tuberculosis
☐	Chest Pain/Condition	☐	Hemorrhoids	☐	Nosebleeds	☐	Ulcers
☐	Chronic Fatigue	☐	Herniated Disc	☐	Osteoporosis	☐	Varicose Veins
☐	Coldness in Extremities	☐	High Blood Pressure	☐	Pacemaker	☐	Venereal Disease
☐	Constipation	☐	Hot Flashes	☐	Polio	☐	Other: _____

Family Health History

Please note any family history of the following conditions and include relationship of relative to you:

☐ Cancer _____
☐ Diabetes _____
☐ Headache _____
☐ High Blood Pressure _____
☐ Arthritis _____
☐ Epilepsy _____
☐ Heart Disease _____
☐ Stroke _____
☐ Spine or Back Disorder _____
☐ Multiple Sclerosis _____
☐ Psychological Problems _____
☐ Other: _____

Secure Online Portal

We now offer a secure online portal that gives you direct access to ask the doctor questions, send documents, or allow him to send you any necessary information. You can request to be sent a clinical summary after each visit to keep for your records. The doctor will respond to all inquiries within one business day. You will need an email address in order to access the portal. Please let us know if you need help setting one up. If you list an email address, you will be sent an invitation to join the portal.

*By signing you agree to receive appointment reminders by text or email. We will not text or email you for any other reason. If you prefer to receive them by text message we will need your service provider. Please provide a cell phone number and/or an email you use regularly so that you can receive the reminder. Please note that appointments missed or not cancelled with at least 24 hours notice will incur a $25 fee. If you prefer not to receive reminders, please let us know.

I have answered the above questions to the best of my knowledge. If I had any questions or concerns about this paperwork I have had them answered before signing this document. I will update the information relevant to this form as it changes.

_____ Date: _____

Patient's Signature

_____ Date: _____

Doctor's Signature

----------For Office Use Only----------

*If current smoker, assessment and cessation intervention is needed. Was this completed? ☐ Yes ☐ No

*Was dietary consult and follow up plan completed? ☐ Yes ☐ No ☐ N/A