# Health Choice Chiropractic

To save time and to allow us to better serve you, Please complete all questions Case No.

| | | | | | |
|---|---|---|---|---|---|
| Full Name (Last name, First name, middle initial) | | | | Today's Date | |
| Address | | City | | State | Zip Code |
| Home Phone | Work Phone | Cell Phone | Pager or Alternate Contact # | | |
| Date of Birth | Sex (Male or Female) | Age | Marital Status S M D W | E-mail Address | |
| Occupation | | Spouses Occupation | | Number of Children | |
| Social Security Number | | Spouses Social Security Number & Date of Birth | | | |
| Driver's License Number | | Referred By (ok to send thank you letter) | | | |

Do you or your spouse have any of the following? Please check

Flexible Spending Account (FSA)_____ Health Savings Account (HSA)_____ Health Reimbursement Account (HRA)_____

Health Care Assistance Plan (HCAP)_____ Medical Savings Account (MSA)_____ Other_____

| | | |
|---|---|---|
| Patient's Employer Name, address & phone number | | |
| Patient's Insurance Companies name & address | | |
| Contract # | Group # | Phone # |
| Spouses Employer Name, address & phone number | | |
| Spouses Insurance Company name & address | | |
| Contract # | Group # | Phone # |

| | |
|---|---|
| Do you Smoke? ☐ Yes ☐ No<br>If yes, how often? ☐ Light ☐ Moderate ☐ Heavy | Do you Drink? ☐ Yes ☐ No<br>If yes, how often? ☐ Light ☐ Moderate ☐ Heavy |

Emergency Contact Information (Name, Phone Number, and Address):

| | | |
|---|---|---|
| What is your major complaint? | Have you ever had Chiropracic Care? If so, when & where? | |
| How long has it been bothering you? | Has it bothered you before? | When? |

**Please indicate if you are here for care because of:** ☐ Auto accident ☐ Work injury ☐ Home injury

| | |
|---|---|
| Brief Description of injury/accident: | Date |

Have you ever had any falls, auto accidents or any type of injuries in the past?

| Date MM/DD/YY | Type of Accident or Injury | Describe Accident or Injury |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever been hospitalized or had any surgeries?

| Date MM/DD/YY | Type of hospitalization or surgery | Comments |
|---|---|---|
| | | |
| | | |
| | | |

Are you presently taking any medication or vitamins?

| Name of Drug or Vitamin | Doses per day | Length of time taking |
|---|---|---|
| | | |
| | | |

| | |
|---|---|
| Do you have a primary care physician? ☐ Yes ☐ No | If yes, Who? And where are they located? |

Please check any of the following that give you difficulty.

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus Trouble
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hayfever
- ☐ Asthma
- ☐ Loss of taste
- ☐ Tightness of throat
- ☐ Thyroid trouble
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Lights bother eyes
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Tightness of shoulder muscles
- ☐ Pain in shoulders and arms
- ☐ Pins and needles in arms and hands
- ☐ Cold hands
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ Mid-back pain
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Nerves and nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Cold sweats
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Low back pain
- ☐ Ulcers
- ☐ Numbness
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual cramps and pain
- ☐ Menstrual irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painfull joints
- ☐ Swollen joints
- ☐ Pinched nerves in back
- ☐ Pins and needles in legs
- ☐ Swollen ankles
- ☐ Cold feet
- ☐ Pains in legs and feet

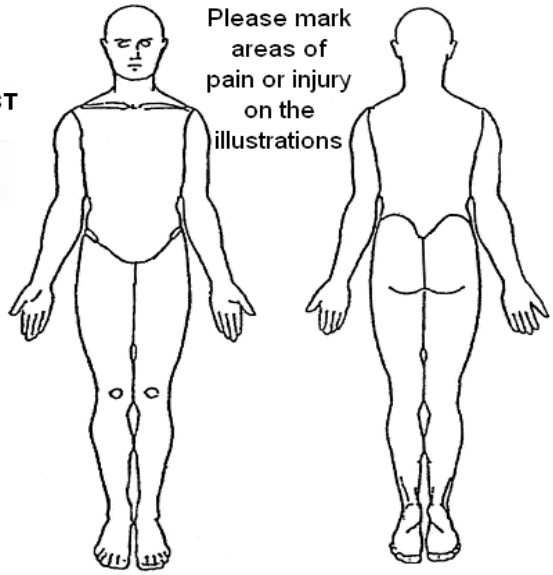
Please rate your pain scale:
With 1 being the least pain and 10 being the most pain

LEAST PAIN — WORST PAIN

0 1 2 3 4 5 6 7 8 9 10

Front Back

Please mark areas of pain or injury on the illustrations



**NOTE:** It is understood and agreed that the amount paid to Health Choice Chiropractic for X-Ray, is for examination only and the original X-Ray scan will remain the property of this office, being on file where they may be seen while a patient of this office.

SIGNATURE OF APPLICANT_____ DATE_____

**DO NOT WRITE BELOW THIS LINE**

Doctor's Use Only

COMMENTS_____

_____

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_____

_____

Work Restriction ☐ Yes ☐ No No work from_____to_____

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