Welcome to our office! It is an honor to be of service to you and your family.
Our commitment to you is to promote the highest quality of health with Chiropractic care.
Chiropractors have become the primary care doctors for millions of people around the world.
Regardless of your reason for visiting our office today, my goal is to become
your family's trusted provider and resource for living a healthy lifestyle
throughout your lifetime.

In Health, Dr. Kristen

Patient Information

Name _________________________________ Birthdate ______________ Gender ❒M ❒F

Primary Phone (______________________) Email Address _____________________________

Address ______________________________City _______________ State ________ Zip ________

Your Condition is/may be related to ❒Auto Accident ❒Work Related Accident ❒Other ❒Non Accident

Who referred you to this office? _____________________________________

Occupation ____

Initial Exam Fee Structure

Please let us know how you intend to pay by selecting one of the options below.

❒**Cash Paying Patient**	❒**Cash Paying Patient** CUSA Discount Network ($39 membership fee)	❒**Out of Network Patient** All other Insurance carriers (if needing to meet deductable)
Initial Exam with adjustment $237	Initial Exam with adjustment $65 + $39 (includes your 1 yr membership)	Initial Exam with adjustment $237
You Pay: $65 when referred **You Pay: $125 without referral**	**You Pay: $104**	**You Pay: ____ per your Ins. Plan**

Initial ______ I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports to assist me in processing insurance claims. I am ultimately responsible for all fees rendered.

Reason For This Visit

Date the symptoms/conditions began? _______________
Describe the symptoms/conditions of this visit:
____
____

Describe your pain:
❒ Burning ❒ Sharp ❒ Dull ❒ Ache
What caused the condition? ________________________

What aggravates the condition? _____________________

What relieves the condition? _______________________

Has this condition occurred before? ❒ Yes ❒ No
Date: ___________ Explain: ____________________
____

Have you seen other doctors for this? ❒ Yes ❒ No
Dr.'s Name (s) ______________________________
Type of treatment ____________________ Date: ________
Results ___________________________________

Is it: ❒ getting worse ❒ staying constant ❒ off & on

Does this condition interfere with:
❒ work ❒ sleep ❒ daily routine ❒ other activities

Rate your Primary Condition (Circle below):

	No Pain								Extreme Pain
Pain:	1	2	3	4	5	6	7	8	9	10
Weakness:	1	2	3	4	5	6	7	8	9	10
Numbness:	1	2	3	4	5	6	7	8	9	10
Tingling:	1	2	3	4	5	6	7	8	9	10
Stiffness:	1	2	3	4	5	6	7	8	9	10
Restriction:	1	2	3	4	5	6	7	8	9	10

Health Habits

Have you missed work or school as a result of your symptom/condition? ❒ Yes ❒ No

	No	**Yes**	**# of:**
Smoke?	❒	❒	______ packs
Drink alcohol?	❒	❒	______ drinks
Cook at home?	❒	❒	______ per wk
Eat out for meals?	❒	❒	______ per wk
Drink coffee (energy drinks)?	❒	❒	______ drinks
Exercise?	❒	❒	______ per wk
High Stress Levels?	❒	❒	

If yes, ❒ work related ❒ financial ❒ relationships
❒ other ______________________________________

Do you wear? ❒ Heel Lifts ❒ Orthotics

Sleeping posture? ❒ Side ❒ Back ❒ Stomach

Check Symptoms Experiencing

❒ Headache
❒ Dizziness
❒ Light Bothers Eyes
❒ Diarrhea
❒ Neck Pain
❒ Feet Cold
❒ Neck Stiff
❒ Tingling in arms/hands
❒ Ears Ring
❒ Hands Cold
❒ Sleeping Problems
❒ Tingling in Legs/feet
❒ Nausea
❒ Back Pain
❒ Numbness arms/hands
❒ Constipation
❒ Nervousness
❒ Numbness legs/feet
❒ Loss of Balance
❒ Tension
❒ Shortness of Breath
❒ Fainting
❒ Fatigue
❒ Chest pain/rib pain
❒ Pain in arms/hands
❒ Jaw Pain
❒ Loss of Strength - arms
❒ Burning muscle pain
❒ Loss of strength - legs
❒ Sharp/shooting pain
❒ Weight gain /loss problems
❒ Allergies/Sinus Problems
❒ Loss of Hair
❒ Heart Surgery/Peacemaker

Past Medical History

List previous accidents (auto, work, sports, etc.)

1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________

List surgeries / hospitalizations / Date
1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________

Do you now or have you ever had?
❒ Heart Disease ❒ Diabetes ❒ Cancer ❒ Stroke
❒ High Blood Pressure ❒ Thyroid Problem ❒ Asthma
❒ Tuberculosis ❒ Prostate Disorder ❒ Kidney Problems
❒ Seizure Disorder ❒ Allergies Type(s): ______________

List Medications &/or Supplements / Reason
1. ______________________ Reason: _________________
2. ______________________ Reason: _________________
3. ______________________ Reason: _________________
4. ______________________ Reason: _________________

Family Health History

The age of your oldest grandparent on record; _______ ❒ Still living ❒ Deceased
Number of Children / Ages and Health Conditions:

Name __________________Age _______ Conditions ____
Name __________________Age _______ Conditions ____
Name __________________Age _______ Conditions ____
Name __________________Age _______ Conditions ____

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke	Other ________________
Father's Side	❒	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒	❒

Goals For My Care

On a scale from 1 – 10, with 10 being the highest, circle the rate of your commitment in helping us solve your current symptom/condition? 1 2 3 4 5 6 7 8 9 10

As a result of my chiropractic care, I would like to (Please check all that apply)
❒ Feel better quickly ❒ Live a healthier lifestyle ❒ Have a healthier spine and nervous system

Do you have other health goals (fertility, weight loss, sleep, energy, etc): ____

Please check the type of care desired so that we may be guided by your wishes whenever possible.
Your doctor will weigh your needs and desires when recommending your treatment program.

❒ Crisis Care: Symptomatic relief of pain or discomfort

❒ Corrective Care: Correcting the cause of the problem as well as the symptoms

❒ Lifestyle Care: Nurture the function of the body proactively to enhance quality of life and correct problems before pain and symptoms occur

❒ I want the doctor to select the type of care appropriate for my condition.

Upon the completion of your 2nd visit, you will receive a Report of Findings consultation which will discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your next visit so you can choose the level of participation that supports you in reaching all of your health goals.

Awareness of Chiropractic Principles

Were you aware that …….

Doctors of chiropractic work with the nervous system?	❒Yes	❒No
The nervous system controls all bodily functions and systems?	❒Yes	❒No
Chiropractic is the largest natural healing profession in the world?	❒Yes	❒No

Experience With Chiropractic

Have you been adjusted by a chiropractor before? ❒Yes ❒No
Reason for those visits? ____
Approximate date of last visit? _______

Has any *adult* in your family seen a chiropractor? ❒Yes ❒No
Has any *child* in your family seen a chiropractor? ❒Yes ❒No