Welcome to Richland Chiropractic Center

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Patient Information

Patient Name Last: _____ First:_____ MI:_____ Date:_____

Address: _____City:_____ State:_____ Zip:_____

Date of birth: ____/____/____ Age: _____ Gender: _____ Marital status: _____

Primary Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

Email address: _____

Whom can we thank for referring you: _____

Employment status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Retired

☐ Unemployed ☐ Full time student ☐ Part time student ☐ Other

Job title:_____

Name of employer:_____ Employer Phone: ( )_____

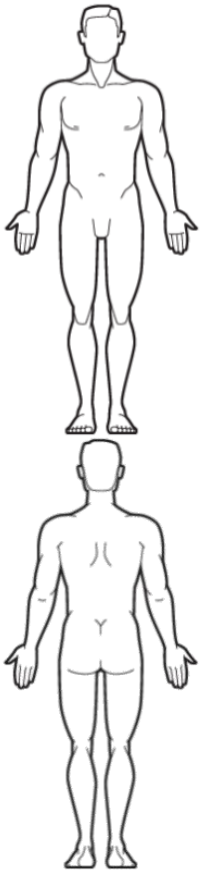
Brief job description:_____

Primary Care Provider: _____ Phone: ( )_____

EMERGENCY CONTACT Name: _____ Relationship: _____

Home/Cell phone: ( )_____ Work phone: ( )_____

Patient Condition



Reason for visit: _____

When did your symptoms appear? _____

Is condition due to an **auto** or **work** accident? □ No □ Yes

Is the condition getting: □ Better □ Worse □ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain):_____

Mark on line: Least pain ——————————————— Severe Pain

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Tingling □ Aching

□ Shooting □ Burning □ Cramps □ Stiffness □ Swelling □ Other: _____

Is the pain any better or worse any time of the day? _____

Is it constant or does it come and go? _____

Activities or movements that are *painful* to perform: _____

□ Sitting □ Standing □ Walking □ Bending □ Lying Down □ Movement

Activities or movements that *alleviate* pain: _____

□ Sitting □ Standing □ Walking □ Bending □ Lying Down □ Movement

Does the discomfort interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Health History

What treatment have you already received for your condition?

□ Medications □ Surgery □ Physical Therapy □ Chiropractic □ None □ Other:_____

Name of doctor(s) who have treated you for your condition: _____

Have you had any testing or diagnostic imaging of the area of complaint or other regions? □ Yes □ No

If yes, please explain:_____

*Please check the appropriate boxes for any **Past** or **Current** conditions:*

□ AIDS/HIV	□ Emphysema	□ Measles	□ Rheumatoid Arthritis
□ Alcoholism	□ Epilepsy	□ Migraine Headaches	□ Rheumatic Fever
□ Allergy shots	□ Fractures	□ Miscarriage	□ Scarlet Fever
□ Anemia	□ Glaucoma	□ Mononucleosis	□ STD
□ Anorexia	□ Goiter	□ Multiple Sclerosis	□ Stroke
□ Appendicitis	□ Gonorrhea	□ Mumps	□ Suicide Attempt
□ Arthritis	□ Gout	□ Osteopenia	□ Thyroid Problems
□ Asthma	□ Heart Disease	□ Osteoporosis	□ Tonsillitis
□ Bleeding Disorders	□ Hepatitis	□ Pacemaker	□ Tuberculosis
□ Breast Lump	□ Hernia	□ Parkinson's Disease	□ Tumors, Growths
□ Bronchitis	□ Herniated Disc	□ Pinched Nerve	□ Typhoid Fever
□ Bulimia	□ Herpes	□ Pneumonia	□ Ulcers
□ Cancer	□ High Blood Pressure	□ Polio	□ Vaginal Infections
□ Chemical Dependency	□ High Cholesterol	□ Prostate Problem	□ Whooping Cough
□ Chicken Pox	□ Kidney Disease	□ Prosthesis	□ Other
□ Diabetes	□ Liver Disease	□ Psychiatric Care	

If needed, explain any of the marks above:

Are you pregnant? □ No □ Yes Due Date:

	Description	**Date**
Falls	_____	_____
Major Injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____

Lifestyle Habits

Exercise: □ None □ 1-2 times/week □ 3-4 times/week □ over 4 times/week

Exercise goals: _____

Smoking: □ No □ Yes Packs/day _____

Alcohol: □ No □ Yes Drinks/week _____

Coffee/caffeine: □ No □ Yes Cups/day_____

Stress Levels: □ Low □ Med □ High Reason: _____

Diet: On a scale from 1 (least healthy) to 10 (most healthy), how healthy is your diet (circle)? 1 2 3 4 5 6 7 8 9 10

Dietary goals: _____

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Please check the boxes that apply to any direct relatives:

□ Diabetes	□ Autoimmune disease	□ Arthritic disorder	□ Neurological disorder
□ High blood pressure	□ Thyroid disorder	□ Cancer or tumors	□ Other_____

By signing, I am acknowledging that all information is accurate to the best of my knowledge. I will not hold the doctors or staff at Richland Chiropractic Center responsible for any omissions or errors made while filling out this form.

If you choose to use insurance, the doctor and staff may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature:_____ Date:_____

Informed Consent

Your doctor will use your medical history and an examination to determine the most accurate diagnosis and treatment plan for your unique condition. Your diagnosis and the proposed treatment plan will be discussed with you and you will have the opportunity to ask questions. You will also be informed of any alternative options available to you.

We encourage you to ask questions if there is anything that you do not understand.

Although chiropractic is very safe, we would like to inform you of the risks that may occur from a chiropractic treatment: pain, headache, dizziness, muscle soreness and stiffness. There are also risks of remaining untreated. Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles.

By signing below, I am consenting to chiropractic treatment.

Patient signature: _____ Date: _____

If patient is a minor or otherwise unable to give consent:

Parent or legal guardian name: _____

Relationship to patient: _____

Signature: _____ Date: _____