ABOUT THE PATIENT

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____City _____ State _____ Zip _____

Cell Phone _____ Height _____ Weight_____ Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? □ No □ Yes

How did you hear about us? ❑ Website ❑ Internet Search ❑ Referral From _____

Emergency Contact _____ ph. # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Fit for Life Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____ Pain Scale (ten being the worst)? 1 2 3 4 5 6 7 8 9 10

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing

❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Worse in the morning ❑ Worse in evening

❑ Mild ❑ Moderate ❑ Severe ❑ Pain radiates to_____

2_____ How long has this been an issue? _____ Pain Scale (ten being the worst)? 1 2 3 4 5 6 7 8 9 10

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing

❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Worse in the morning ❑ Worse in evening

❑ Mild ❑ Moderate ❑ Severe ❑ Pain radiates to_____

3. **Are you Pregnant?** ❑ Yes: How many weeks? _____ ❑ No

4. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

5. What makes it better? ❑ Ice ❑ Heat ❑ Medication ❑ Other: _____

6. What makes it worse? ❑ Bending ❑ Sitting ❑ Standing ❑ Other: _____

7. What Doctor's have you seen for this? _____

_____

8. Type of treatment: _____

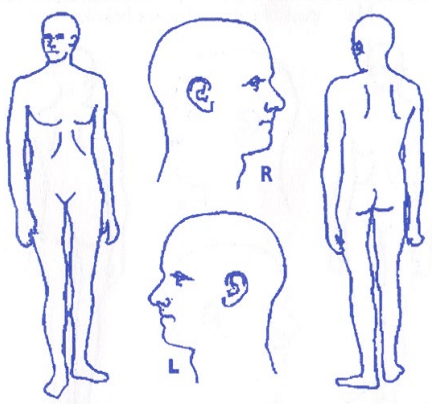
9. Results: _____

NOTES: _____

_____

_____

Please mark all areas of concern.



GENERAL CHILD/INFANT HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma (Circle)	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo._____ Total during lifetime_____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit _____/_____/_____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home
7. Complications During Pregnancy: ❑ No ❑ Yes Explain: _____
8. Ultrasounds During Pregnancy: ❑ No ❑ Yes How Many: _____
9. Medication During Pregnancy / Delivery ❑ No ❑ Yes List: _____
10. Cigarette / Alcohol Use during Pregnancy: ❑ No ❑ Yes
11. What age at each Milestone:

_____Raising Head

_____Crawling

_____Introduction to Solid Food

_____Walking

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____