

Scott Family Chiropractic

Health Card # _____ Version Code _____

Name: _____

Address: _____
(Street) (City/Town/Village) (Postal code)

Home # _____ Work # _____ Cell# _____
Where do you prefer to be contacted: Home ___ Work ___ Cell ___

Email: _____
(we do not trade, sell, or share any of our email addresses)

Date of Birth: _____ Occupation: _____
day / month / year

Marital Status: _____ Name of Spouse: _____

Children: no () yes () how many? _____ Indicate if you are or may be pregnant ()

How did you hear about our office? : _____
(Please be specific)

What is the main reason for consulting our office today? _____

What goals would you like to achieve for your health? _____

When was the last time you felt your best? _____

Describe affected areas: _____

When did this problem start? _____

How often does this problem affect you? _____

What makes this problem worse? _____

What makes this problem better? _____

How does this affect your work? _____

How does this affect your family life? _____

How does this affect your ability to enjoy sports, hobbies, life, etc.? _____

Rate your commitment level to assisting us in your care. (1-low, 10-high) _____

Rate your commitment level to achieving your health goals. (1-low, 10-high) _____

Date of your last chiropractic exam? _____

What was the chiropractor's name? _____

Personal Habits: (Please specify - heavy, moderate, light or n/a)

Alcohol _____ Coffee/Tea/Cola _____ Tobacco _____ Prescription Drugs _____

List your current medications and what they are for: _____

How well do you sleep? _____

Please list any broken bones, injuries, accidents, falls or surgery you have ever experienced.

Please check the conditions you experience frequently or are currently experiencing.

HEAD/NECK

headaches /migraines ___ vision problems ___ earaches/ ear noises ___ ear infections ___

RESPIRATORY

chronic cough ___ shortness of breath ___ allergies/sinus ___
recurrent colds/infections ___ breathing problems ___ asthma ___

CARDIOVASCULAR

High/low blood pressure ___ poor circulation ___ heart disease ___ phlebitis ___
varicose veins ___

DIGESTIVE/URO-GENITAL

difficult digestion ___ constipation ___ liver/gall bladder ___ kidney/bladder ___

OTHER CONDITIONS

insomnia ___ cancer ___ arthritis ___ loss of weight ___ diabetes ___ thyroid ___
nervousness /anxiety ___ swollen glands ___ menopausal/menstrual issues ___

MUSCLES JOINTS (CURRENT/PAST PAIN OR STIFFNESS)

neck ___ mid-back ___ shoulders ___ low back ___ upper back ___
right knee ___ left knee ___ right leg ___ left leg ___ Other _____

OTHER CONDITIONS/CONCERNS

I have read and agree that all information provided is accurate to the best of my knowledge. I also agree, that once explained to me, I will participate in my health care and policies and agreements that go with my chiropractic care. I understand and agree that health and accident insurance policies are an arrangement between myself and the carrier. I will be provided all the necessary receipts to be reimbursed. I understand that if I suspend or terminate my care all fees are due and payable for services rendered. I hereby consent to a preliminary consultation, examination, scans or other diagnostic testing that will assist the doctor in determining if I am a chiropractic case. If chiropractic care is prescribed, I also agree to chiropractic adjustments, based on my decision to choose chiropractic care. I understand and agree that as in all health care, there are some slight risks and that I have been examined in order to determine if I am at risk and the doctor has explained all aspects of my care. I will rely on the doctor's judgment during my course of care. I intend this consent to cover the entire course of my care in this office.

Patient Signature _____ Date _____

Witness Signature (C.H.A.) _____