Health **Solutions**

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Welcome to our office. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in improving and maintaining your health.

Today's date _____/_____/_____

Name_____ **Height** _____ **Weight** _____
Last First Initial

Address _____**City** _____ **State** _____ **Zip** _____

Phone #: (_____) _____-_____ **Cell Phone #:** (_____) _____-_____ **Sex:** M F **Age:** _____**Birth Date:** ____/_____/_____

Marital Status: Single Married Separated Divorced **Email address:** _____

Patient employed by _____ **Occupation** _____

Business Address _____**Business Phone #** (_____) _____-_____

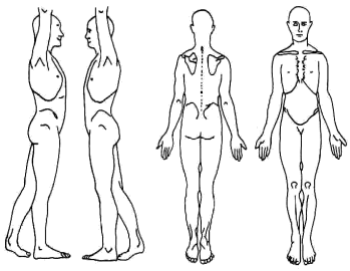
Whom may we thank for referring you to our office? _____

Notify in case of emergency: _____ **Relation:** _____**Phone:** (_____) _____-_____

Reason for Visit

Have you ever seen a chiropractor? Yes No If yes, when? _____ Reason: _____

Mark an "X" on ALL areas of complaint/pain (designate left and/or right side):



Head	Neck	Shoulder	Trap	Briefly describe your symptoms in your own words:
Mid Back	Low Back	Hip	Rib	_____
Arm	Elbow	Wrist	Hand	_____
Leg	Knee	Ankle	Foot	_____

When did symptom(s) begin? _____ Have you had this condition in the past? Yes No

Average pain intensity on a scale of 0 -10 (circle when at its worst): **no pain** 0 1 2 3 4 5 6 7 8 9 10 ***worst pain***

How often do you experience your symptoms?

Constant (76 - 100% of the time) **Frequent** (51- 75%) **Occasional** (26- 50%) **Intermittent** (1 – 25%)

Type of Pain: Sharp Dull Throbbing Aching Burning Tingling Numbness Cramping Stiffness Swelling
Other: _____

Activities/movements difficult to perform: Sitting Walking Bending Lying Down Lifting Standing Cough/Sneeze

Is your pain interfering with**:** Work Sleep Daily Routine Recreation Exercise Other: _____

What makes your condition better? _____ worse?_____

Health History

Have you been treated by a medical physician or any other professional for your condition? Yes No If yes, state name of doctor, when and where seen? **Describe in detail:** _____

Please list all medications (including pain killers) you are taking: _____

Please list & date any recent or past **injuries/surgeries/auto accidents** (i.e.: falls, broken bones, traumas, etc.):

_____

List recreational activities and/or sports that you currently are involved in or have been involved in the past?

_____

Women: Are you pregnant? Yes No If so, how far along? _____ Nursing? Yes No Due date: _____

Medical Conditions/History

Please circle any of the following health conditions that apply to **YOU or FAMILY – if family, denote with an "F"**?

Pacemaker	Artificial Bones/Joints	Psychiatric Issues
High Blood Pressure	High Cholesterol	Diabetes
Aneurysm	Congenital Heart Defect	Shingles
Heart Attack/Stroke	Cancer	HIV(+)/ AIDS/ Hepatitis
Fainting	Vertigo/dizziness	Severe Frequent Headaches
Arthritis/Gout	Spinal Fusions	Scoliosis
Neuropathy	Hypothyroid	Kidney Problem

Lifestyle Information

Smoker? Yes No
Regular Alcohol Consumer? Yes No
Sitting # of hours per day_____
Regular Exercise? Yes No What type? _____ How often? _____
Regular Supplementation? Yes No Please list: _____
Daily Water Intake (on avg.)?_____ **what kind? Circle: tap, filtered, bottled, ionized, spring**
Rate your Stress level from 1-10 (circle): Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest_____
Are you aware of any allergic/sensitivity reactions toward any food items, air-borne particles, chemicals, perfumes? Yes No If yes, please list: _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by **Health Solutions** to help determine appropriate health services. If there is any change in my medical status, I will inform the doctor immediately. I also understand that all patient related information is kept strictly confidential by Health Solutions and released only by prior authorization of the patient or a legal guardian of the patient.

I authorize my insurance company to pay Health Solutions all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Health Solutions to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ **Date** _____/_____/_____

****Payment is due in full at the time services are rendered unless prior arrangements have been approved.****