

General Information

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

Phone: _____ Cell Home

Occupation: _____

Employer: _____

How did you hear about/find us? _____

Is this your first visit to a Chiropractic Physician?

No Yes

Emergency Contact Info

Name: _____

Relationship: _____

Phone: _____ Cell Home

Dr.'s Notes

Reason for Visit

What brings you in today? _____

Have you received treatment for this condition in the past?

No Yes

If yes, where? _____

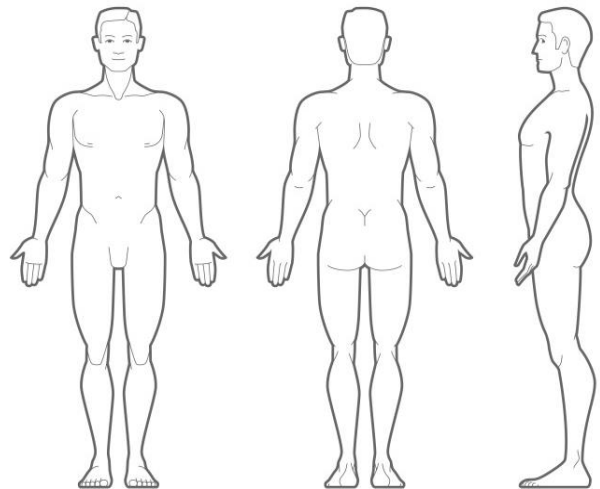
When? _____

Are you seeking treatment related to an accident?

Auto Work Other No

Using the symbols below, please mark any areas where you're experiencing:

x Pain ⊙ Numbness or Tingling # Burning



How severe is your pain on a scale of 0 to 10:

On Average? _____ At worst? _____ At best? _____

Check the boxes that best describe your symptoms:

Constant Comes & goes Worse at night

Worse in the morning Sharp Dull

Aching Shooting Throbbing

When did your symptoms first appear? _____

What (if anything) makes it better? _____

What makes it worse or irritates it? _____



Health History

Recent signs & symptoms: (Please check all that apply.)

- Constant Pain
- Unexplained Weight Loss/Gain
- Loss of Bladder Control
- Abnormal Bleeding
- Fatigue
- Excessive Thirst
- Frequent/Painful Urination
- Excessive Bruising
- Fever, Chills, Sweats
- Nausea/Vomiting
- Blood in Urine
- Difficulty Breathing
- Change in Appetite
- Severe Abdominal Pain
- Black/Bloody Stools
- Tightness in Chest

Are you currently pregnant? No Yes, Due Date: _____

Have you ever had any of the following conditions?

- Cancer
- Hypertension
- Recurring Sinusitis
- Disc Herniation/Bulge
- Anemia
- Pacemaker
- Bloating
- Arthritis
- Bleeding Disorder
- Stroke
- Belching/Gas
- Osteoporosis
- Bruise Easily
- Swelling in Ankles/Legs
- Kidney Disease
- Rheumatoid Arthritis
- Clotting Disorder
- Allergies
- Anxiety
- Latex Allergy
- Cardiovascular Disease
- Glaucoma
- Depression
- Psoriasis
- Heart Attack
- Recurring Ear Infections
- Drug/Alcohol Dependency
- Sprained Ankle

Please list any injuries, hospitalizations or surgeries, with approximate dates: (broken bones, appendicitis, etc...)

Medications

Vitamins

Allergies

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Don't sign me up for a free **HealthWave** account that will save me 20% on professional brand health products.

Dr.'s Notes



Lifestyle

Exercise

- None
- Minimal
- Moderate
- Daily
- Excessive

Work Activity

- Sitting
- Standing
- Light Labor
- Medium Labor
- Heavy Labor

Habits

- Smoking Frequency: _____
- Alcohol Frequency: _____
- Recreational Drugs Type: _____
- Coffee/Caffeine Frequency: _____
- High Stress Reason: _____

Nutrition

How would you describe your eating habits?

- I eat whatever and whenever I want.
- I make an attempt to eat right, but struggle.
- Most of the time I eat right, but treat myself on occasion.
- I strictly regulate my food intake, all the time.
- I'm all over the board. No consistency

Sleep

Average hours of sleep per night? _____

I normally sleep on my:

- Back
- Stomach
- Side
- Toss & Turn

Authorization to Provide Care

I authorize the physicians at Upright Health Muscle & Joint Care to administer manual manipulations, advanced soft tissues techniques, passive therapies and/or any treatment they deem appropriate, for the purposes of regaining and/or maintaining musculoskeletal health, unless I expressly refuse beforehand.

Initial: _____

Receipt of Notice of Privacy Practices

I have been offered a copy of Upright Health Muscle & Joint Care's Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand I can review this notice anytime at www.uprighthealth.us/npp.pdf

Initial: _____

Payment Policy

I understand that payment for services rendered, per the fee schedule listed at <http://uprighthealth.us>, will be due on the date of service and accepted in the forms of cash, check or charge. I may choose to submit a reimbursement claim directly to my insurance provider. UprightHealth will supply any additional documentation regarding my treatment, needed for this purpose, at my request.

Initial: _____