Welcome

First Name _____

Last Name _____

Middle Initial _____ Nickname ___ _____

Address _____

_____

City _____

State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____

Sex ☐M ☐F Date of Birth _____

Status ☐Single ☐Separated ☐Married ☐Widowed ☐Divorced

Name of spouse (if applicable) _____

Whom may we thank for referring you? _____

How did you first hear of this clinic? _____

Have you ever seen a chiropractor before? ☐Y ☐N

Where? _____ When? _____

Employer/Occupation_____

Who is responsible for payment? ☐Self ☐Spouse ☐Guardian ☐Other

If not "Self":
Name_____

Address_____

Phone(s)_____

Who is the primary insured? ☐Self ☐Spouse ☐Guardian ☐Other

If not "Self":
Name_____

Insured's Employer _____

Date of Birth _____ SSN (optional) _____

Children (names/ages)_____

Reasons for today's visit:

☐maintenance/wellness care ☐stiffness ☐spasms ☐numbness ☐tingling ☐headache ☐neck pain ☐TMJ ☐arm pain

☐shoulder pain ☐lost range of motion ☐elbow pain ☐wrist pain ☐carpal tunnel ☐back pain ☐sciatica ☐disc problem

☐sacroiliac pain ☐hip pain ☐leg pain ☐knee pain ☐ankle pain ☐foot pain ☐fibromyalgia ☐auto accident ☐sports related

Describe _____

Nature of your symptoms: ☐dull ☐achy ☐sharp ☐burning ☐numb ☐tingling ☐other _____

Circle pain range, from 0 (none) to 10 (remarkably severe): ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Frequency of pain as percentage of day: ☐constant, 76-100% ☐frequent, 51-75% ☐occasional, 26-50% ☐intermittent, 0-25%

When and how did symptoms begin? _____

_____

Authorization:

I have received a copy of the Richards Family Chiropractic HIPAA Privacy Policy (available upon request). I authorize my insurance company to pay to Dr. David Richards and/or Richards Family Chiropractic all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature _____ Date _____

Past Medical History

		Describe	*Date*
Auto Accidents	☐None		
Falls	☐None		
Head Injuries	☐None		
Broken Bones	☐None		
Dislocations	☐None		
Surgeries	☐None		
Artificial Bones/Joints	☐None		
Other Serious Injuries	☐None		

List any diagnosis, condition or disease you may have: ☐None

_____

_____

_____

_____

_____

_____

_____

_____

_____

Checkmark (✓) the box that describes your habits:

	Heavy	Moderate	Light	None
Alcohol				
Recreational Drugs				
Tobacco				
Coffee / Caffeine				
Appetite				
Exercise				
Sleep				

Current medications:

_____

Other providers seen for your condition:

_____

If you currently have any of the following, indicate this with a "C" in the box, if you've had it only in the past, indicate this with a "P":

Eye, Ear, Nose & Throat

- ☐ Vision Problems
- ☐ Eye Infection / Inflammation
- ☐ Ear Pain or Discharge
- ☐ Ringing in Ears / Tinnitus
- ☐ Hearing Loss
- ☐ Sore Throat or Hoarseness
- ☐ Difficult or Slurred Speech
- ☐ Sinus Problems
- ☐ Allergy Problems
- ☐ *Other* _____

Gastro-Intestinal System

- ☐ Poor Appetite
- ☐ Difficulty Chewing / Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea / Constipation
- ☐ Black or Bloody Stool
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ *Other* _____

Cardio-Vascular-Respiratory

- ☐ Chest Pain
- ☐ Heart Problems
- ☐ Blood Pressure Problems
- ☐ Vascular Disorders
- ☐ Lung Problems
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ *Other* _____

Musculoskeletal System

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulders
- ☐ Shoulder Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ *Other* _____

Nervous System

- ☐ Numbness, *where* _____
- ☐ Spasms, *where* _____
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle Jerking
- ☐ Confusion
- ☐ Depression / Psychiatric Problems
- ☐ Insomnia
- ☐ *Other* _____

Genito-Urinary System

- ☐ Bladder Trouble
- ☐ Discolored Urination
- ☐ Urination is Difficult or Painful
- ☐ Sexually Transmitted Disease
- ☐ *Other* _____

Miscellaneous

- ☐ Breast Prosthesis or Implant
- ☐ Pregnant, due date: _____
- ☐ Cancer: _____
- ☐ Osteoporosis
- ☐ *Other* _____

This information is thorough and accurate to the best of my knowledge. I understand that this information is necessary to determine the appropriate management of my condition. If there is any change in my medical status, I will inform the doctor.

Signature _____ Date _____