Name ____ Preferred Name _________________________

Address ______________________________________ City ______________ State ___________ Zip __________

Phone(s) Home ____________________________ Cell __________________________ Work ______________________

- *Please indicate primary phone # you would like us to use.*

Email ____ Age ________ Date of Birth _______________ Gender F M

- *Please inform our office of any address or telephone number changes.*

Marital Status M S D P W # of children ______

Emergency Contact __________________________ Relationship __________________ Phone ____________________

Employment: Full Part None Student Employer ______________________ Occupation _________________________

How did you hear about us? ○ referral (from whom) ____
○ internet ○ yellow pages ○ drive by ○ other ________________________________

Do you have medical insurance? Y N (please allow us to copy your insurance and ID cards, including secondary)

Are you here due to an accident? Y N
If yes, have you retained an attorney? Name of attorney ____

PAYMENT AGREEMENT
Payment is due at time of service. We accept cash, check, Visa, MasterCard and Discover. In the case of health insurance, we will collect in full until we know what your insurance covers. Once we have a history of how your insurance pays, we will collect your co-payment or co-insurance at time of service.

FINANCIAL AGREEMENT
I have read and understand A Healing Space, Inc's Financial Policy. I understand that I can ask for a paper copy of this policy at any time.

PRIVACY POLICY
I have read and understand A Healing Space, Inc's Notice of Privacy Practices. I understand that I can ask for a paper copy of this policy at any time.

ASSIGNMENT OF INSURANCE BENEFITS
I authorize A Healing Space, Inc. and it's agents to submit claims to my insurance carrier(s) on my behalf. I authorize direct payment to the provider rendering services of any insurance benefits otherwise payable to me.

I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

____
Signature of Patient or Guardian Date

A Healing Space

Name____Date____________

Main Complaint? ____

Did your main complaint come on? Gradually Suddenly Is it getting? Better Worse Staying the Same

When did problem begin? ____

What do you think was the cause? ___________________________________

What makes it better? ____

What makes it worse? ____

Have you had this problem in the past? Yes No If yes when? ____________________

Have you had chiropractic care in the past? Yes No For what reason? ________________

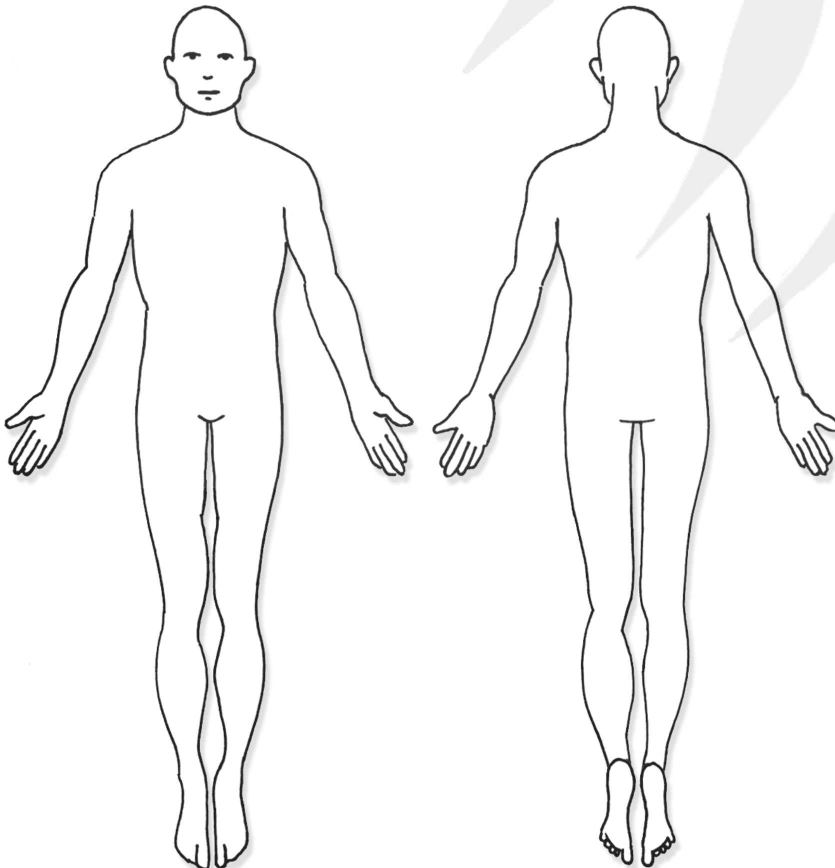
Have you had any X-Rays or MRI? Yes No Of what body part? ___________________

Does a cough, sneeze, strain make it worse? Yes No Does problem interfere with sleep? Yes No

BODY DIAGRAM

Please rate each pain on diagram on a scale of 1 (a little) - 10 (extreme)

S=sharp **N**=numb **A**=achy **O**=other_____



C=Currently **P**=In the Past **N**=Never

headache	C	P	N
migraine	C	P	N
neck pain	C	P	N
mid back pain	C	P	N
lower back pain	C	P	N
shoulder pain	C	P	N
hip pain	C	P	N
knee problems	C	P	N
ankle problems	C	P	N
feet problems	C	P	N
fatigue	C	P	N
gout	C	P	N
constipation / diarrhea	C	P	N
urinary problems	C	P	N
high blood pressure	C	P	N
depression	C	P	N
seizures	C	P	N
paralysis	C	P	N
muscle weakness	C	P	N
numbness or tingling	C	P	N
vertigo or dizziness	C	P	N
loss of balance	C	P	N
stroke	C	P	N
loss of smell	C	P	N
fainting	C	P	N
cancer	C	P	N
varicose veins	C	P	N
osteoporosis	C	P	N
HIV	C	P	N
hypoglycemia	C	P	N
diabetes	C	P	N
Are you pregnant	C	P	N
arthritis	C	P	N

Name____ Date______________

Weight:__________ Height: __________

Please list major and minor surgeries (with year or age)

1. ______________________ 2.______________________

3. ______________________ 4:______________________

When did you last go to a doctor's office, medical clinic, or hospital? What was the reason?______________

Please list significant traumas/accidents: ______________________

Please list all medications you take: ______________________

I am here for (check one)

- ☐ Pain Relief Only - Stop Here, you are done.
- ☐ Improve my health / Correct the cause of my problem - Please finish the rest of the form

Please list all Vitamin/ Mineral/Herbs/Nutritional supplements you take: ______________________

What are your health concerns in order of importance?

1. ______________________ 2.______________________

3. ______________________ 4.______________________

5. ______________________ 6.______________________

How do your health concerns affect your everyday living? ______________________

What do you feel needs to happen for you to get better? ______________________

How much change are you willing to make at this time for improving your health?

Minimal Some Complete

Place a mark on the line that best describes you currently. (use last 3 months for reference):

Mood

Extremely Depressed |----|----|----|----|----|----|----|----|----| Very Happy

Overall Health

Dying |----|----|----|----|----|----|----|----|----| Extremely Healthy

For the following questions please indicate your average (A) and worst (W) levels. Use either the last 3 months or since there has been a problem which ever is shorter.

Energy Level

None |----|----|----|----|----|----|----|----|----| Extremely Energetic

Pain Level

None |----|----|----|----|----|----|----|----|----| Worst Pain Imaginable

Stress Level

None |----|----|----|----|----|----|----|----|----| Extreme Stress