



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

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? _____

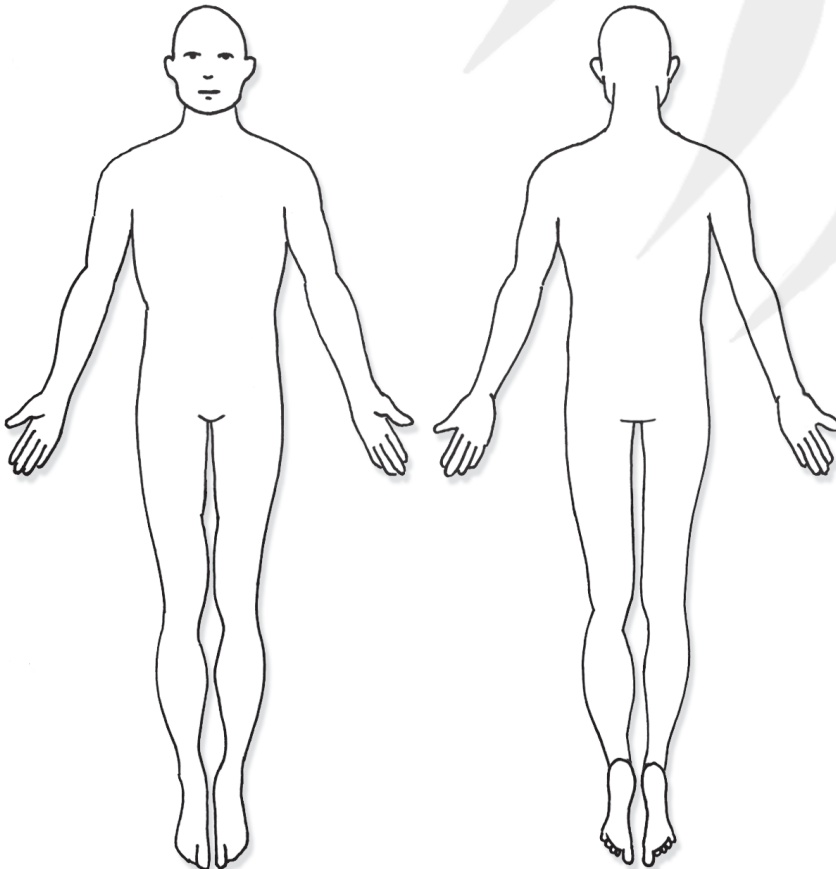
Have you had any X-Rays or MRI? Yes No Of what body part? _____

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



Overall Health



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



Pain Level



Stress Level

