Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Phone(s) Home _____ Cell _____

Email _____ Age _____ Date of Birth _____

Sex Assigned at Birth _____ Current Gender Identity _____ Pronouns _____

Marital Status M S D P W Number of Children _____

Emergency Contact _____ Relationship _____ Phone _____

Employment Full Part None Student Employer _____ Occupation _____

How did you hear about us? (Referral; From who) _____

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

Are you here due to an accident? Y N

If yes, have you retained an attorney? Name and Phone of Attorney _____

PAYMENT AGREEMENT

Payment is due at the time of service. We accept cash, check and credit/debit cards. In the case of health insurance, it is your responsibility to understand what your insurance covers. We will do our best to verify your insurance benefits before the end of your appointment and we will collect either your co-pay or in full if there is a deductible that must first be reach at the time of service.

CANCELLATION POLICY

You agree that all appointment **cancellations and reschedules require 24 hours notice** and agree to the following: There will be a **$35 fee** assessed to your **first** appointment cancelled without the required notice. All subsequent cancellations or reschedules without the required notice will incur a fee equal to the **full amount of services scheduled**.

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 any 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.

Patient or Guardian Signature _____ 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 the problem begin? _____

What makes it better? _____

What makes it worse? _____

Have you had this problem in the past? Y N If yes, when? _____

Have you had chiropractic care in the past? Y N If yes, when? _____

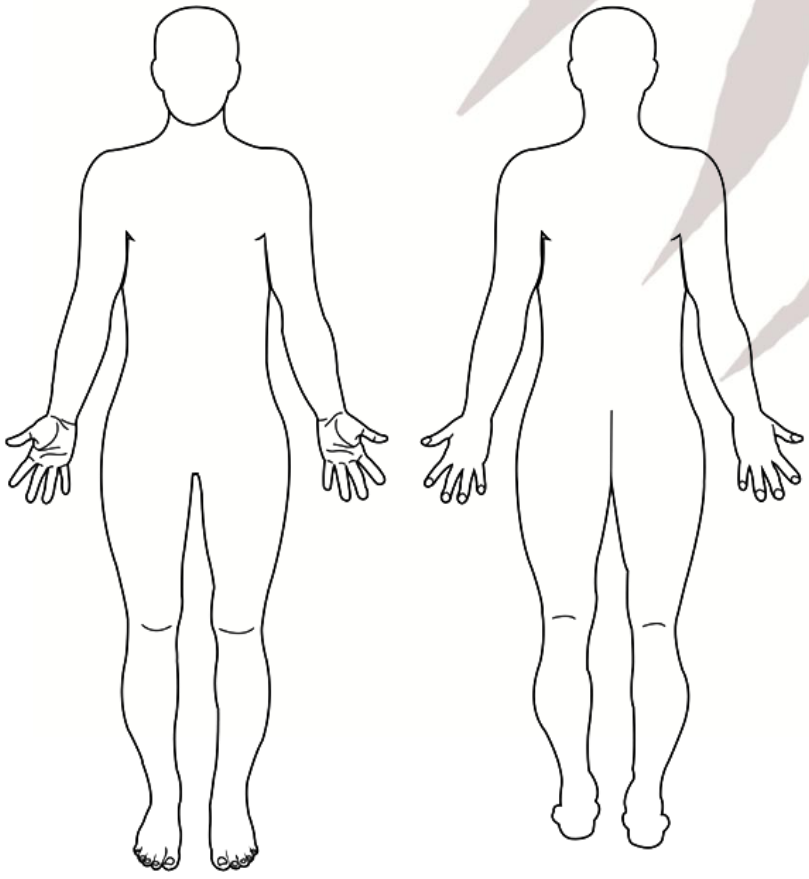
Have you had any X-Rays or MRI? Y N Of what body part? _____

Does a cough, sneeze, or strain make it worse? Y N Does the problem interfere with sleep? Y N

Body Diagram

Please rate each pain on diagram on a scale from 1 (a little) – 10 (extreme)

S=Sharp **N**=Numb **A**=Achy **O**=Other _____



C=Currently **P**=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
Arthritis	C	P	N
Are you pregnant?	C	P	N

Name _____ Date _____

Weight _____ Height _____

Please list any minor or major surgeries (with year or age):

1. _____ 2. _____

3. _____ 4. _____

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

_____

Do you have any autoimmune diseases or other health complications not previously listed? If so, what are they? _____

_____

Please list any significant traumas or accidents. _____

_____

Please list all medications you take. _____

_____

I am here for:

- ☐ 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/herbal/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?_____

_____

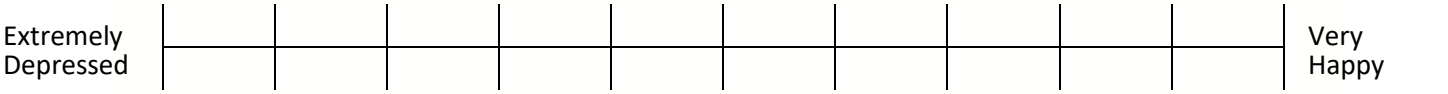
What do you feel needs to happen for you to get better? _____

_____

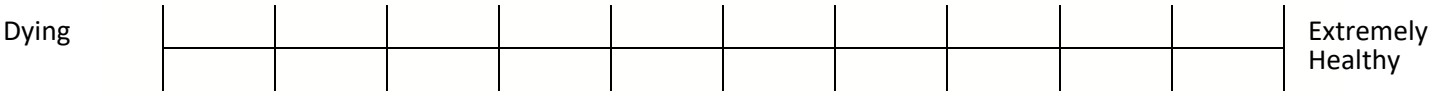
How much change are you willing to make at this time for improving your health? Minimal Some Complete

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

Mood



Overall Health



For the following, please indicate your average (**A**) and worst (**W**) levels. Use either the last 3 months or since there has been a problem, whichever is shorter, for reference:

Energy Level

Pain Level

Stress Level