Fully Alive Chiropractic
335 N. Main St., Ste.21, Springboro, OH 45066
(937) 748-9708 (p) ~ (937) 806-3281 (f)

Confidential Patient Information

Patient's Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

How did you hear about our office? ○ Website ○ Sign ○ Google ○ Magazine ○ Church Bulletin ○ Patient ○ Other_____

If referred by a friend or patient, whom may we thank for their referral?_____

Family Physician: _____ (Note: May we send your health information to this provider? **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Fully Alive Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

Your Health Profile

Why This Form is Important

As a Neurologically-Based Chiropractic office, we focus on your ability to be healthy through balancing your nervous system. Our goals are, first, the issues that brought you to our office, and second, to offer you the opportunity of improved health potential and peak performance services in the future.

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Please answer the following:

Physical Stress

Was YOUR birth traumatic? Yes ❍ No ❍

What sports did you play in school?

_____

Did you have serious childhood falls or traumas?

_____

_____

Any auto accidents (even minor)? Please List with Year it Occurred.

_____

_____

Any other serious falls or injuries (please list with year)?

_____

_____

Have you had surgery (please list with year)?

_____

_____

Have you had a fractured or broken bone? List

_____

Emotional Stress

At what age(s) were you for your 3 most impactful emotional stresses?

_____

On a scale of 1-10, what would you rate an average day of stress in your life? _____

Where in your body do you hold or carry your stress?

_____

Chemical Stress

Were you vaccinated? Yes ❍ No ❍

Has there been any prolonged use of medication? Yes ❍ No ❍

What are your current medications?

_____

_____

Do you smoke? Yes ❍ No ❍

Do you drink alcohol or caffeine on a daily basis? Yes ❍ No ❍

What Brought You Into Our Office?

If you have no symptoms or complaints and are here for peak performance services, please check here____ .

Chief Complaints_____

If you are experiencing pain it is....
❍ Sharp ❍ Dull ❍ Comes & Goes ❍ Travels

❍ Constant

Since the problem started, it is.....

❍ Getting Better ❍ About the same
❍ Getting Worse

What makes it worse?_____

_____

The pain interferes with: ❍ Work ❍ Sleep
❍ Walking ❍ Sitting ❍ Hobbies ❍ Socializing
❍ Personal Care ❍ Lifting ❍ Reading
❍ Concentration ❍ Driving ❍ Sex Life

Please list other practitioners you have seen for this issue.

Chiropractor_____

Medical Doctor_____

Other_____

Please check all symptoms you have had, even if they do not seem to relate to your current problem.

General ❍ Allergies ❍ Dizziness ❍ Fainting ❍ Fatigue ❍ Headache ❍ Nervousness ❍ Depression ❍ Numbness or Tingling

Muscle & Joint ❍ Arthritis ❍ Bursitis ❍ Hernia ❍ Neck Pain/Stiffness ❍ Foot Trouble ❍ Wrist Pain ❍ Elbow Pain ❍ Shoulder Pain ❍ Arm Pain ❍ Hand Pain ❍ Mid Back Pain ❍ Rib Pain ❍ Hip Pain ❍ Knee Pain ❍ Chest Pain ❍ Leg Pain ❍ Low Back Pain ❍ Sciatica ❍ Ankle/Foot Pain ❍ Tail Bone Pain ❍ Spinal Curvature ❍ Swollen Joints

Gastro-Intestinal ❍ Diarrhea ❍ Belching/Gas ❍ Colitis ❍ Poor Digestion ❍ Constipation ❍ Bloating ❍ Reflux ❍ Diabetes ❍ Gallbladder ❍ Hemorrhoids ❍ Poor Appetite ❍ Pain Over Stomach

Eyes, Ears, Nose &Throat ❍ Asthma ❍ Deafness ❍ Ear Ache ❍ Ear Noises ❍ Eye Pain ❍ Enlarged Glands ❍ Thyroid Condition ❍ Sinus Infections

Cardio-Vascular ❍ High Blood Pressure ❍ Low Blood Pressure ❍ Poor Circulation ❍ Irregular Heart Beat ❍ Swelling of Ankles ❍Murmur

Respiratory ❍ Chest Pain ❍ Chronic Cough ❍ Difficult Breathing

Skin ❍ Acne ❍ Bruises Easily ❍ Varicose Veins

Genito-Urinary ❍ Bed Wetting ❍ Unable to Control Urine ❍ Kidney Infections/Stones ❍ Painful Urination ❍ Prostate Problems

Women Only ❍ Menstrual Cramps/Backache ❍ Excessive Flow ❍ Irregular Cycle ❍ I Am Currently Pregnant.

Your Health Beliefs

What tools have you used to try to reduce stress?

_____

_____

How do you support your health?

_____

_____

What bad habits do you need to release?

_____

_____

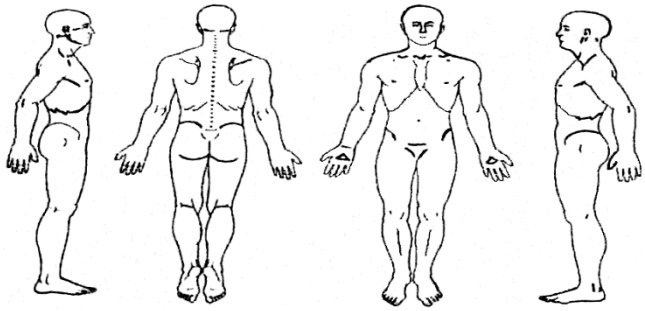
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are <u>worse</u> in the (circle what applies)

-morning -Increase during the day

-afternoon -same all day

-night -decrease during the day

3. When did your symptoms begin (onset date)? _____
4. How did your symptoms begin? _____
5. Have you experienced these before? _____
6. Do your symptoms radiate? _____
7. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

   If No, what have you tried that has not helped? _____
8. Have you been treated for this before? ____No ____Yes How long ago? _____
9. What treatment did you receive? _____
10. Results of previous treatment? ____Good ____Poor Comments _____
11. List any other major injuries you have had, other than those mentioned previously: _____

_____

12. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____