





## REASON FOR VISIT

Is the reason for today's visit:  Well-being & Wellness (go directly to page 3)  A Specific Problem

Is your specific problem a result of (Please circle): work, sports, auto, trauma or chronic.

Explain what happened: \_\_\_\_\_

Please describe the pain & its location: \_\_\_\_\_

When did condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Is this condition getting worse?  Yes  No  Constant  Comes & goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

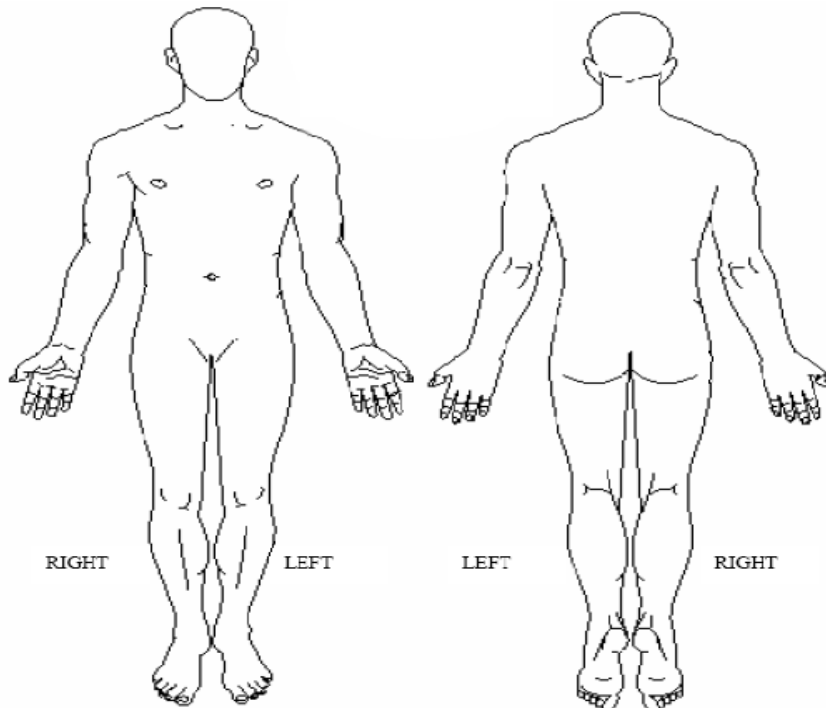
If so, where? \_\_\_\_\_

Have you ever been under a Chiropractor's care before?  Yes  No

## SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Mark with the appropriate symbols and indicate degree of pain as follows:

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
 (mild discomfort) (extreme pain)  
 Numbness = N Pins & Needles = P Burning = B Aching = A Stabbing = S Example: "S4" or "A9"





# HEALTH HISTORY

Who is your Medical Doctor? \_\_\_\_\_ Phone #: \_\_\_\_\_

May we have your permission to contact your doctor?  Yes  No

Are you taking any:  Prescription Drugs (please list) \_\_\_\_\_

Over the Counter Drugs (please list) \_\_\_\_\_

**Do you have or have you ever had any of the following conditions?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack/Stroke        | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery/Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect    | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse   | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Valves |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse         | <input type="checkbox"/> Y <input type="checkbox"/> N STD                     | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis         |
| <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS                  | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Neck Pain         | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema/Glaucoma      | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia            |
| <input type="checkbox"/> Y <input type="checkbox"/> N High/Low Blood Pressure    | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Headaches  | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems         | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers/Colitis    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/Seizures/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems          | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes/Tuberculosis      | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing    | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lower Back Problems        | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis         |

Please list any other serious medical condition (s) you have or ever had: \_\_\_\_\_

Please list anything to which you may be allergic: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List **any** past accidents, injuries or broken bones with dates: \_\_\_\_\_

Family Health History: \_\_\_\_\_

Do you take supplements or vitamins?  Yes  No Do you exercise?  Yes  No

What is your current weight: \_\_\_\_\_ lbs., and height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Are you on a special diet?  No  Yes Since: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type: \_\_\_\_\_

Do you smoke?  No  Yes How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Are you wearing:  Heel Lifts  Sole Lifts  Inner Soles  Arch Supports

What is the age of your mattress? \_\_\_\_\_ Is it comfortable?  Yes  No

**For Women:** Are you taking Birth Control?  Yes  No

Are you pregnant?  No  Yes/How many weeks? \_\_\_\_\_ Are you nursing?  Yes  No



## ACCOUNT INFORMATION

## Who is the person ultimately responsible for the account?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Payment Method:  Cash  Check  Credit Card \_\_\_\_\_ / \_\_\_\_\_  
CARD # EXP.

\_\_\_\_\_ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.  
INITIALS I fully understand I am solely responsible for any balance not paid by my insurance company.

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- ◆ I authorize the staff of Slak Chiropractic Group to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Adult Patient  Parent or Guardian  Spouse

# Welcome to Slak Chiropractic Group!

We look forward to a long and healthy relationship with you.