SHAW Chiropractic
Spinal Health And Wellness

Patient Information:

Date: _____

Name (First, Middle, Last): _____
Preferred Name: _____ Birthdate: _____ Sex: [ ] Male [ ] Female
Phone #: Home _____ Mobile _____ Work _____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____
(Email Address is used for Birthday Cards, Special Events, and Periodic Newsletters. Information is never given out)
Employer: _____ Occupation: _____
Emergency Contact: _____ Relation: _____ Phone #: _____
How did you hear about us? [ ] Activator Site [ ] ICPA Website [ ] Internet [ ] Sign [ ] Other _____
[ ] Referred by Friend/Family _____

Women:

Are you pregnant?	[ ] Yes [ ] No	Are you taking birth control?	[ ] Yes [ ] No
Do you have irregular cycles?	[ ] Yes [ ] No	Are you nursing?	[ ] Yes [ ] No
Do you experience painful periods?	[ ] Yes [ ] No	Do you have breast implants?	[ ] Yes [ ] No

Infants:

[ ] Normal Delivery [ ] C-section Delivered by: [ ] OBGYN [ ] Midwife Normal APGAR Scores at birth? [ ] Yes [ ] No
[ ] Breast fed [ ] Bottle fed [ ] Both Latching Difficulties? [ ] Yes [ ] No How often having bowel movement? _____
Does child seem to have equal range of motion with neck? [ ] Yes [ ] No
Does baby flinch with touch or arch back? [ ] Yes [ ] No
Complaints: [ ] Colic [ ] Constipation [ ] Reflux [ ] Ear Infections [ ] Constantly Sick [ ] Other _____

Goals for your care:

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

[ ] I want the Doctor to select the type of care appropriate for my condition

- [ ] Relief care: Symptomatic relief of pain or discomfort.
- [ ] Corrective care: Correcting and relieving the cause of the problem as well as the symptom
- [ ] Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Chiropractic Experience:

Have you ever been adjusted before? [ ] Yes [ ] No If yes, Why? _____
Which technique did they use? [ ] Manual [ ] Manual with drop pieces [ ] Activator [ ] Other Instrument [ ] Upper Cervical
[ ] Other _____

Reason for this Visit:

What brought you in today? [ ] Auto Accident [ ] Pain/Discomfort [ ] Wellness Care/Maintenance Care

Describe symptoms: _____

_____

_____

How would you describe the pain/discomfort (dull, achy, sharp, throbbing, etc.)? _____

Does the pain/discomfort: [ ] stay in one spot [ ] travel to another location _____

When did this concern begin? _____ Has it: [ ] Gotten Worse [ ] Stayed Constant [ ] Come and gone

How would you rate discomfort on scale of 1-10 (1 is no pain, 8 is childbirth, 10 pain so bad about to lose consciousness)

Current Level _____ At its worst _____ At its best _____

Have you seen other doctors for this concern? [ ] Yes [ ] No Treatment Received_____

When is the pain at its worst? [ ] Morning [ ] Mid-day [ ] Evening [ ] Night [ ] Worse with activity

What activities (walking, bending, carrying, etc.) make it feel worse? _____

_____

What activities (walking, bending, carrying, etc.) make it feel better? _____

_____

Patient Social:

Water:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never	Soft Drinks:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Exercise:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never	Caffeine:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Homemade Food:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never	Alcohol:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Processed:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never	Tobacco:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Diet Food Products:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never	Drugs:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never

Personal Incident History:

Broken Bones: [ ] Yes [ ] No Treatment: [ ] Yes [ ] No Explain: _____

Sprains/Strains: [ ] Yes [ ] No Treatment: [ ] Yes [ ] No Explain: _____

Hospitalized: [ ] Yes [ ] No Explain: _____

Surgery: [ ] Yes [ ] No Explain: _____

Auto Accident: [ ] Yes [ ] No Treatment: [ ] Yes [ ] No Explain: _____

Struck Unconscious: [ ] Yes [ ] No Treatment: [ ] Yes [ ] No Explain: _____

Eating Disorder: [ ] Yes [ ] No Explain: _____

Stroke: [ ] Yes [ ] No Explain: _____

Personal Health History:

Current Conditions (mark all that have apply currently or in the last 3 months):

[ ] Allergies	[ ] Alcoholism	[ ] Anemia	[ ] Arteriosclerosis	[ ] Arthritis
[ ] Asthma	[ ] Back Pain	[ ] Breast Lump	[ ] Bronchitis	[ ] Bruise Easily
[ ] Cancer (ever had)	[ ] Chest Pain	[ ] Cold Extremities	[ ] Constipation	[ ] Cramps
[ ] Depression	[ ] Diabetes	[ ] Digestion Problems	[ ] Dizziness	[ ] Excessive Menstruation
[ ] Eye Pain or Difficulties	[ ] Fatigue	[ ] Frequent Urination	[ ] Headache	[ ] Hemorrhoids
[ ] High Blood Pressure	[ ] Hot Flashes	[ ] Insomnia	[ ] Irregular Heart Beat	[ ] Irregular Menstrual
[ ] Kidney Infection	[ ] Kidney Stones	[ ] Loss of Balance	[ ] Loss of Memory	[ ] Loss of Smell
[ ] Loss of Taste	[ ] Nosebleeds	[ ] Pacemaker	[ ] Polio (ever had)	[ ] Poor Posture
[ ] Prostate Trouble	[ ] Sciatica	[ ] Shortness of Breath	[ ] Sinus Infection	[ ] Spinal Curvatures
[ ] Stroke (ever had)	[ ] Swelling of Ankles	[ ] Swollen Joints	[ ] Thyroid Condition	[ ] Tuberculosis (ever had)
[ ] Ulcers	[ ] Varicose Veins	[ ] Venereal Disease		

Current Medications: _____

Current Supplements: _____

Family Health History:

Has any member of your family (Sibling, Parent, and/or Grandparent) had a history of:

Cancer: [ ] Yes [ ] No Type_____ Relation_____
Type_____ Relation_____
Type_____ Relation_____

Diabetes: [ ] Yes [ ] No Relation_____

Heart Disease: [ ] Yes [ ] No Relation_____

High Blood Pressure: [ ] Yes [ ] No Relation_____

I certify that I am the patient or legal guardian listed above. I have read/understood the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctor(s) see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I am aware that there are possible risks of chiropractic care and I hereby give my informed consent to be treated at SHAW Chiropractic.

Signature_____ Date_____

Auto Accident Financial Responsibility:

Auto accident care is billed primarily through your auto insurance carrier under the Personal Injury Protection (PIP) coverage. Your carrier will then recover that money from the other insurance company if another party is at-fault. When your combined bills (from all providers seen) exceed the amount of PIP coverage then all parties have to wait for a settlement to be reached either directly through the third party adjuster or by way of a Personal Injury Attorney. During this waiting period we at SHAW Chiropractic will carry the balance with a signed Lien Waiver. Sometimes the settlement takes a while to recover and our office spends time going back and forth with the Attorney or the Insurance Adjuster to monitor the progress of the case. As a result of this extra time spent on the case and holding the bill until settlement, our office reserves the right to add a 2% interest charge per month until a settlement is reached. To avoid any interest being added to the final bill you can elect to make a minimum of a $25 payment per month which then will be recovered with the settlement.

Signature_____ Date_____