

DATE: _____

SUNSHINE CHIROPRACTIC

CHART: _____

Patient Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS #: _____ Sex: Male Female Marital Status: Single Married Widowed Divorced

Email: _____ Referred By: _____

Occupation: _____ Employer: _____

Spouse Name: _____ Spouse Birthdate: _____ Spouse SS #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Patient Complaints: _____

Date Symptoms Began _____

How Problem Began _____

Is this Work Related Auto Related Unknown

Current Complaint (How You Feel Today)										
0	1	2	3	4	5	6	7	8	9	10
No Pain								Unbearable Pain		

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household chores)										
0	1	2	3	4	5	6	7	8	9	10
No Interference						Unable to carry on activities				

SSS=Stabbing

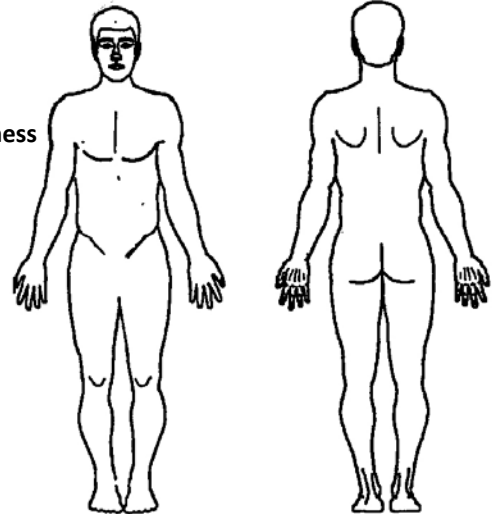
Place symbol on Pain Area

PPP=Pins & Needles

AAA=Aching

BBB=Burning

NNN=Numbness



How often are your symptoms present? (0-25% 26-50% 51-75% 76-100%) (Day or Week)

What Makes Your Condition Better? Exercise Heat Ice Lying Down Medications
 Rest Sitting Standing Stretching

What Makes Your Condition Worse? Bending Coughing Lifting Sitting
 Sneezing Standing Walking

Please check all of the following that apply to you:

Please check all that apply to your family History:

- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke Date _____
- Use Cortisone/Prednisone
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor _____

- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Pregnant #Weeks _____
- Abnormal Weight Gain Loss
- Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Epilepsy/Seizures

- Cancer
- Diabetes
- Heart Problems
- Stroke
- Rheumatoid Arthritis
- High Blood Pressure

Other Health Problems _____

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Weight: _____ Height: _____ Blood Pressure: _____

List all Surgeries and Dates: _____

Current Medications: _____

Current Vitamins and Minerals: _____

List Anything You are Allergic To: _____

Have you ever seen a Chiropractor before? Yes No If Yes, Who and When? _____

Family Physician _____ Date Last Seen _____

Smoking: Never <1 pack/day 1-2 packs/day Over 2 packs/day

Caffeinated Drinks: Never 1 glass/day 2-3 glasses/day More than 3 glasses/day

Alcohol Consumption: Never 1 glass/day 2-3 glasses/day More than 3 glasses/day

Exercise: Never 1 day/week 2-3 days/week More than 4 days/week

Kinds of Exercise: _____

The undersigned agrees to and understands all information of this agreement. I accept financial responsibility for services given regardless of insurance reimbursement to provider. Our policy requires payment in full for all service rendered at the time of visit, unless other arrangements have been made with Sunshine Chiropractic employee. If account is not paid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

I hereby consent to the performance of examination and treatment on my by the licensed doctors of chiropractic, certified therapy assistants and any other technical support staff who may be employed or engaged in practice in this clinic. I understand that while very small, there are certain degrees of risk associated with chiropractic care and with any and all supportive physical therapeutic modalities. These risks include, but are not limited to fracture disc injury, stroke, sprains, strains and soreness. I am therefore willing to accept and consent to the risks associated wit the care I am about to receive.

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 Patient Guardian

Date