Please Print Legibly **Personal Information**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Jr / Sr*

*Last First M.I.*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address Apartment/Unit #*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*City State ZIP Code*

Primary Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ H / M / B Alternate Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ H / M / B

Birth Date: \_\_\_\_/ \_\_\_\_/\_\_\_\_\_\_ Social Security Number #: \_\_\_\_\_-\_\_\_\_ -\_\_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you the insured on this Policy? \_\_\_ Yes \_\_\_ No

If No, Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Married \_\_\_ Single \_\_\_ Other

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits and Release of Records**

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to Dr. David J. Bax D.C. Inc. for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payers, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me.

**Financial Obligation**

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. In the event that my insurance sends payment directly to me, I agree to immediately deliver said payment to David J. Bax D.C. Inc.

I understand that I am responsible for understanding my insurance benefits and limitations and will not hold this practice responsible for any misquoted benefit information. I also understand it is my responsibility to notify this practice of any changes, including but not limited to insurance, health care coverage, address, phone number or physical condition, before signing in for my appointment. Any billing errors resulting in non-payment of my claims will be my financial responsibility.

I understand that this practice holds the right to charge me for any missed appointment not cancelled at least 24 hours in advanced. I understand this fee will be my responsibility and will not be charged to my insurance.

I understand payment in full is expected within 30 days from receiving my statement advising me of a balance due. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to any interest that can be added at the current legal rate, attorney fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts.

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. If the patient is a minor child, under the age of eighteen at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Responsible Party If Under the Age Of 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent to Treat**

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic therapies, treatment and procedures by Dr. David J. Bax D.C. and his staff.

* I understand that chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments) and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in the clinic.
* I understand that the chiropractor will use his hand or a mechanical device upon my body to adjust a joint which may cause an audible “pop” or “click”.
* As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgement and expertise in working with like cases.
* It is not responsible to expect my chiropractor to be able to anticipate or explain all possible risks and complications of any given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgement during the course of any procedures, which he feels at the time to be in my best interest.
* Any undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
* As with any health care procedure, there are certain complications which may arise during chiropractic adjustments. Those complications include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. These complications are extremely rare occurrences.
* I consent to the performance of diagnostic x-rays as deemed necessary and acknowledge certain risk are associated with x-rays. At this time, I know of no conditions which the taking of x-rays would further complicate.

**Acupuncture**

I understand that acupuncture is performed by insertion of needles through the skin or by the application at certain points on or near the surface of the body in attempt to treat bodily dysfunction to modify or prevent pain perception, and to normalize the body’s physiological functions. I am aware that certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, infection, fainting, pain or discomfort, and possibly temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Privacy Practices**

I understand that some of my heath information may be used and/or disclosed by Dr. David J. Bax D.C., Inc. to carry out treatment, payment or health care operations, and for a more complete description of such uses and disclosers, I should refer to the Notice of Our Privacy Practices. I understand that I may review this privacy notice at any time prior to signing this form. I understand that over time these privacy practices may need to change in accordance with law and that I may obtain a copy of this notice by calling the office to request the current copy of this notice. I understand that for my protection, any request to amend my health information or to access my medical records must be made in writing.

**Motor Vehicle Accidents**

I will inform this practice before signing in if my condition results from a motor vehicle accident, I understand my auto insurance will be billed for any charges I may incur resulting from that accident. I understand that I, not my insurance, will be the responsible party for all fees, in the event of non-payment. I understand that I may retain an approved Personal Injury Lawyer to assist in the coverage of my medical expenses.

|  |
| --- |
| **Consent to Treat Minors**  If my child is under the age of 18, I hereby request and authorize Dr. David Bax to perform diagnostic tests and render chiropractic adjustments and other treatment to my child. This authorization also extends to all other staff members and is intended to include radiographic examination at the doctor’s discretion. I affirm that I have the legal right to select and authorize health care services for the minor child named above.  I declare under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Printed Name Relationship to Patient |

I have read the above consent, or had it read to me, have had the opportunity to ask questions and received answers, am comfortable with the information provided and consent to chiropractic treatment and any other therapies deemed appropriate for my care.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian/Responsible Party

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please Print Legibly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Mark the area of pain/sensation using the appropriate letter listed below. Please be as specific as possible.    P - Sharp Pain  B - Burning  A - Aching Pain  0 - Pins & Needles  N - Numbness  X - Spasm  W - Swelling  S - Stiffness  Pain is  \_\_\_\_ Constant  \_\_\_\_ Comes & Goes  \_\_\_\_ Changes With Weather  \_\_\_\_ Getting Better  \_\_\_\_ Getting Worse  \_\_\_\_ Staying the Same  Better Worse  \_\_\_\_\_ AM \_\_\_\_\_  \_\_\_\_\_ Mid \_\_\_\_\_  \_\_\_\_\_ PM \_\_\_\_\_  I am interested in  \_\_\_Short Term Pain Relief  \_\_\_ Long Term Correction |  |  |

Rate Top Three Areas of Pain Using 0 as no pain and 10 as intolerable pain. When did symptom first appear?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

None Mild Moderate Severe

What makes your pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all activities that cause pain or are difficult to perform:

\_\_\_\_ Lying on Back

\_\_\_\_ Lying On Side

\_\_\_\_ Turning Over in Bed

\_\_\_\_ Lying Flat on Stomach

\_\_\_\_ Sitting

\_\_\_\_ Standing (Over 1 Hour)

\_\_\_\_ Walking Short Distances

\_\_\_\_ Climbing Stairs

\_\_\_\_ Pulling

\_\_\_\_ Kneeling

\_\_\_\_ Reaching

\_\_\_\_ Gripping

\_\_\_\_ Bending

\_\_\_\_ Turning Head

\_\_\_\_ Dressing Self

\_\_\_\_ Driving

\_\_\_\_ Getting In/Out of Car

\_\_\_\_ Coughing/Sneezing

\_\_\_\_ Urination

\_\_\_\_ Bowel Movements

Have you been diagnosed with osteoporosis? \_\_\_\_Yes \_\_\_\_No Have you been diagnosed with cancer? \_\_\_\_Yes \_\_\_\_No

Do you have metal implants? \_\_\_\_Yes \_\_\_\_No Have you had spinal surgery? \_\_\_\_Yes \_\_\_\_No

Have you ever become dizzy or lost consciousness? \_\_\_\_Yes \_\_\_\_No Diagnosed with spinal stenosis? \_\_\_\_Yes \_\_\_\_No

Experience sudden weakness in the arms or legs? \_\_\_\_Yes \_\_\_\_No Feel numbness in the genital area? \_\_\_\_Yes \_\_\_\_No

Do you take Warfarin (Coumadin), Heparin, or other similar “blood thinner”? \_\_\_\_Yes \_\_\_\_No

Do you suffer from any other conditions? (Diabetes, High Blood Pressure, Arthritis, Heart Disease, etc.) If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prescription medications, over the counter medications, vitamins, and supplements you are currently taking (include dosage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever consulted a Chiropractor? \_\_\_\_Yes \_\_\_\_No If yes, list date, doctor’s name, condition, and any complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you consulted an MD for this condition? \_\_\_\_Yes \_\_\_\_No If yes, list date, doctor’s name, results, and any complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any major illnesses, injuries, falls, hospitalizations, auto accidents or surgeries. List date, injury and treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any x-rays taken of your spine? \_\_\_\_Yes \_\_\_\_No Date and where taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEMALE: Date of last menstrual cycle: \_\_\_\_\_\_\_\_\_\_ Date of last gynecological and breast exam: \_\_\_\_\_\_\_\_\_\_

Are you pregnant: \_\_\_\_Yes \_\_\_\_No

MALE: Date of last prostate and testicular exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Health History**

Recreational activities (Hobbies):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per week: \_\_\_

How far do you commute weekly to work and/or school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you a student? \_\_\_No \_\_\_Full Time \_\_Part Time

Do you exercise? \_\_\_Yes \_\_\_No Length Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you smoke? \_\_Yes \_\_No Frequency: \_\_\_\_\_\_\_\_\_\_

Do you consume caffeine? \_\_\_Yes \_\_\_No Beverage and Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcohol? \_\_\_Yes \_\_\_No How much per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Health History**

Health Status of Family Members (If deceased, please explain)

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**System Review Questions**

Check if you have experienced any problems with the following:

\_\_\_\_ Eyes

\_\_\_\_ Ears

\_\_\_\_ Nose, Mouth, Throat

\_\_\_\_ Heart

\_\_\_\_ Lungs/Breathing

\_\_\_\_ Intestines/Colon

\_\_\_\_ Internal Organs

\_\_\_\_ Muscles

\_\_\_\_ Nerves

\_\_\_\_ Skin

\_\_\_\_ Urinary

\_\_\_\_ Blood

\_\_\_\_ Arthritis

\_\_\_\_ Corpal Tunnel

\_\_\_\_ Fibromyalgia

\_\_\_\_ Psychological

\_\_\_\_ Allergies

\_\_\_\_ Sinus Infections

\_\_\_\_ Asthma

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature is an acknowledgement that all of the above statements are true.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian/Responsible Party Signature Date