

# Welcome to Dynamic Family Chiropractic

Check if applicable:

Auto Accident: \_\_\_\_\_ Workers Compensation: \_\_\_\_\_ (If one of these are checked please stop and see front desk)

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home #( ) \_\_\_\_\_ Work #( ) \_\_\_\_\_ Ext. \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Fax #( ) \_\_\_\_\_ Cell #( ) \_\_\_\_\_ E-mail Address \_\_\_\_\_

\_\_\_\_\_ Male \_\_\_\_\_ Female # of Children \_\_\_\_\_ Single Married Widowed Divorced

Employer \_\_\_\_\_ Work Duties \_\_\_\_\_ **WOMEN ONLY: Are you pregnant? NO YES**

Name of Spouse (parent if patient is under 18) \_\_\_\_\_ Birth Date of Spouse (parent if patient is under 18) \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_ Method of payment for First Visit: *Cash Check CC*

## Your Health Profile

**\*\*Please check any symptoms below that you are currently experiencing or have experienced in the past.**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Headaches/Migraines    | <input type="checkbox"/> Pins/Needles in legs/Feet | <input type="checkbox"/> Recurring Infection      | <input type="checkbox"/> Infertility/Miscarriage |
| <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> Loss of Smell             | <input type="checkbox"/> Back Stiffness/Pain      | <input type="checkbox"/> Loss of Balance         |
| <input type="checkbox"/> Dizziness/Vertigo      | <input type="checkbox"/> Buzzing /Ringing in ears  | <input type="checkbox"/> Sinus Problems/Allergies | <input type="checkbox"/> Nervousness/Anxiety     |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Depression                | <input type="checkbox"/> Irritability/Mood Swings | <input type="checkbox"/> Tension/ Stress         |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Neck Stiffness/ Pain      | <input type="checkbox"/> Cold Hands               | <input type="checkbox"/> Cold Feet               |
| <input type="checkbox"/> Diarrhea/Constip./Gas  | <input type="checkbox"/> Foot Problems             | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Hot Flashes             |
| <input type="checkbox"/> Cold Sweats            | <input type="checkbox"/> Light Bothers Eyes        | <input type="checkbox"/> Problems Urinating       | <input type="checkbox"/> Heartburn/Reflux        |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> PMS                       | <input type="checkbox"/> Menopause                | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Jaw/TMJ Problems       | <input type="checkbox"/> Other _____               |   |  |

### Current Health Condition

Chief Complaint (why are you here today): \_\_\_\_\_

\_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has it ever occurred before: \_\_\_ Yes \_\_\_ No

Was this due to an accident/trauma? \_\_\_ Yes \_\_\_ No

If Yes, explain (i.e. fall, auto, sports) \_\_\_\_\_

Symptoms: When this problem is at its worst, can you explain in your own words exactly how it feels? \_\_\_\_\_

Severity \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe

Does this pain travel or radiate? If so, where? \_\_\_\_\_

Quality: (mark all that apply)

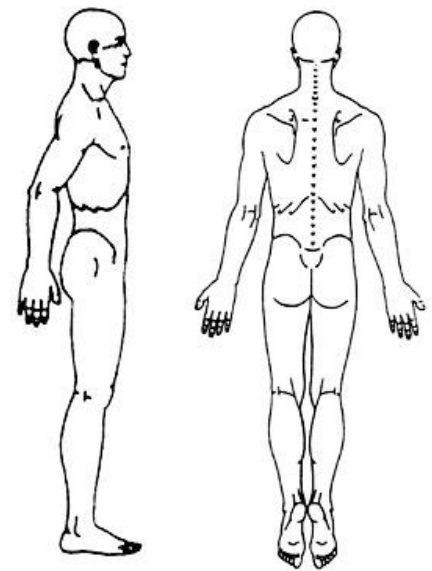
Burning  Dull/Aching  Localized

Sharp  Tingling  Radiating

Is there anything that makes this better or worse? \_\_\_\_\_

\_\_\_\_\_

**\*Please circle the areas where you have any problems on the human body picture below.**



Timing:

- Worse AM                       Worse PM                       Worse W/ Activity                       Worse Sleeping
- Occasional (0-25%)    Intermittent (25-50%)    Frequent (50-75%)    Constant (75-100%)

How often do you find yourself suffering from this problem? \_\_\_\_\_  
 How long does the problem last? (all the details of timing) \_\_\_\_\_  
 What solutions have you attempted to solve this problem? \_\_\_\_\_

**Daily Activities: Effects of Current Condition on Performance**

- |                       |                                    |   |   |  |
|-----------------------|------------------------------------|---|---|--|
| Carrying Groceries    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Changing Positions    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sit to Stand          | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing Stairs       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pet Care              | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving               | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Extended Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Household Chores      | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting Children      | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Reading/Concentration | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Bathing   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Dressing  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Shaving   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sexual Activities     | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting Still         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Standing Still        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard Work             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking               | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Please List any effects that this may have on any Recreational Activities:

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

Are there any other complaints/conditions that the doctor should address? If so, list and describe:

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

Medications: What medications are you currently taking and for what conditions?

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

Have you Had any previous Chiropractic Care? \_\_\_\_\_ If yes, date of last care \_\_\_\_\_

Notes:

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

DX:	X-Rays:
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## Dynamic Family Chiropractic Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

### Dynamic Family Chiropractic Policies / Procedures:

(Please Initial Next to each Line)

- \_\_\_\_\_ 1. All initial services and subsequent fees are payable when services are rendered. (Co-pays, deductibles, ect.)
- \_\_\_\_\_ 2. X-ray films / discs are the property of Dynamic Family Chiropractic. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary with a **\$10.00 processing fee** and will be ready for pick-up within **24 hours** of the time requested.
- \_\_\_\_\_ 3. If Medical Records are requested there will be a copy / processing fee of **ten cents per page** and will be ready for pick up within **24 hours** of time requested.
- \_\_\_\_\_ 4. I have read and understand The Notice of Privacy Act (HIPPA forms, behind New Patient Paperwork)

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff Signature)

\_\_\_\_\_  
(Date)