Family Chiropractic Clinic
of Monroe

First Name: **Last Name:** **Date of Birth:**

Home **Mobile** **Work**

Preferred Communication: (Circle one) **Email:**

Home Mobile Work

Street Address: **Apt/Suite#:**

City: **State:** **Zip Code:**

Gender: **Weight:** **Height:**

Male Female ft in

Employer: **Occupation:**

Spouse's Name: **Spouse's DOB:** **Spouse's Phone Number:**

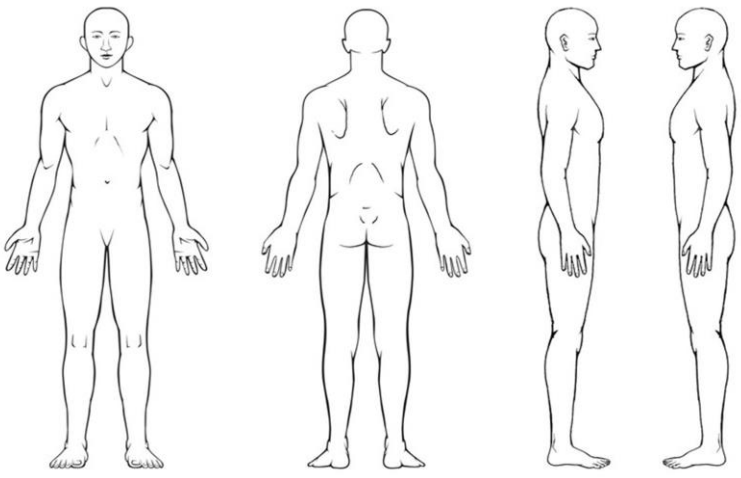
Names of your children and their ages:

Have you ever been treated by a chiropractor before?

No Yes If **YES**, who and when? _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness **B = Burning** **S = Sharp** **T = Tingling** **A = Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did this condition begin? ___/___/_____ **Is it getting worse?** Yes No

How did it begin? _____

What type of symptoms are you experiencing?

Aching	Burning	Dull	Sharp	Stabbing
Throbbing	Stiffness	Weakness	Numbness	Tingling
Other: _____		Radiates into: _____		

Does anything aggravate your pain?

Activity (Heavy)	Activity (Moderate)	Activity (Light)	Bending	Lifting
Stress	Temperature Changes	Twisting	Driving	Movement
Sit to Stand	Sitting	Standing (Prolonged)	Sleeping	
Looking: Up Down Left Right		Other: _____		

Does anything relieve your pain?

Increased Activity	Lying Down	OTC Medication	Heat	Ice
Postural Changes	Stretching	Prescription Medication	Rest	Support Brace
Topical Analgesic	Standing	Other: _____		Nothing

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

Medical Conditions: (circle all that apply)

Arthritis	Cancer	Diabetes	Heart Disease	Hypertension	Psychiatric Illness
Skin Disorder	Stroke	Asthma	Fibromyalgia	Osteoporosis	Other: _____

Surgeries: (circle all that apply)

Appendectomy	Cardiovascular Procedure	Cervical Spine	Hysterectomy	Prostate
Joint Replacement	Gall Bladder	Lumbar Spine	Brain	Shoulder
Thoracic Spine	Gastro-intestinal	Carpal Tunnel	Knee	Hernia
Uro-genital	Breast Augmentation	Other: _____		

Allergies: (circle all that apply)

Mold	Seasonal	Milk or Lactose	Animal	Sulfites	Wheat/Gluten
Chemical _____		Other _____			

Social History:

Caffeine use:	occasional	often	never
Exercise:	occasional	often	never
Drink Alcohol:	occasional	often	never
Recreational Drugs:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>8 hours/night	insomnia

Family History: (circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease:	Parent	Sibling
Hypertension:	Parent	Sibling
Stroke:	Parent	Sibling
Thyroid:	Parent	Sibling

Other: _____

Occupational Activities: (circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment Operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper

Other: _____

Typical Eating Habits:

Skip Meals 3 Meals/Day Snack Between Meals Keto Weight Watchers

Other: _____

Healthy Eating Habits: (0 < 10)

0 1 2 3 4 5 6 7 8 9 10

Please list all supplements you take:

_____

_____

_____

Please list all medications you take:

_____

_____

_____

Do you have any health goals?

_____

_____

_____

Are you pregnant? No Yes If yes, when are you due? _____

Cardiovascular: (circle all that apply to you)

Poor Circulation	Hypertension	Heart Disease	Heart Attack	Chest Pain
High Cholesterol	Pace Maker	Irregular Heart Beat	Swelling of legs	Aortic Aneurism

Respiratory: (circle all that apply to you)

Asthma	Apnea	Tuberculosis	Short Breath	Emphysema
Cold/Flu	Pneumonia	Cough	Wheezing	

Allergic/Immunologic: (circle all that apply to you)

Hives/Rash	Immune Disorder	HIV/AIDS	Allergy Shots	Cortisone Use

Genitourinary: (circle all that apply to you)

Kidney Disease	Burning Urination	Frequent Urination	Blood in Urine	Kidney Stones
Infertility	Prostate Issues	Lower Side Pain		

Neurologic: (circle all that apply to you)

Stroke	Seizures	Head Injury	Numbness	Severe Headache
Pinched Nerves	Parkinson's	Carpal Tunnel	Vertigo	Brain Aneurysm

Constitutional: (circle all that apply to you)

Weight Loss	Weight Gain	Low Energy	Difficulty Sleeping

Eyes: (circle all that apply to you)

Glaucoma	Double Vision	Blurred Vision	Wear Glasses/Contacts

Ear, Nose, and Throat: (circle all that apply to you)

Difficulty Swallowing	Dizziness	Hearing Loss	Sore Throat	Nosebleeds
Bleeding Gums	Sinus Infections	Chronis Ear Infection	Loss of Taste/Smell	Ringing in Ears

Psychiatric: (circle all that apply to you)

Depression	Anxiety	Stress	ADD/ADHD

Endocrine: (circle all that apply to you)

Thyroid Issues	Diabetes	Hair Loss	Menopausal	PMS

Hematologic: (circle all that apply to you)

Hepatitis	Blood Clots	Cancer	Bruising	Bleeding
Fever/Chills	Sweating	Varicose Veins		

Gastrointestinal: (circle all that apply to you)

Food Sensitivity	Bowel Problems	Constipation	Liver Problems	Diarrhea
Ulcers	Nausea/Vomiting	Blood Stool	Poor Appetite	

Musculoskeletal: (circle all that apply to you)

Gout	Arthritis	Joint Stiffness	Muscle Weakness	Osteoporosis
Broken Bones	Joints Replaced	Poor Posture	Scoliosis	Hip Pain
Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain	Jaw Pain/TMJ
Foot Pain	Ankle Pain	Elbow Pain	Wrist Pain	Knee Pain

END OF FORM ACKNOWLEDGEMENT

Chiropractic Care:

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of their health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

Privacy Verification:

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Permission to Contact:

I grant permission to be called or sent a text message to confirm or reschedule an appointment and to be send occasional cards, letters, emails, or health information to me as an extension of my care in this office.

Payment Verification:

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

General Verification:

To the best of my ability, the information I have supplied is complete and truthful. I have no misrepresented the presence, severity or cause of my health concern.

Signature of Patient or Guardian: _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by Thomas J. Thompson, D.C. and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Signature of Patient or Guardian: _____ Date: _____

Signature of Doctor or Staff: _____ Date: _____