NEW PRACTICE MEMBER

Name_____ **Date of Birth** ____ /____ /____ **Age**____ **Male/Female**

Address_____ **City**_____ **State**_____ **Zip**_____

Phone: Cell (_____)_____ **Home (_____)**_____ **Cellular Provider** _____

Social Security Number: _____--_____--_____ **Email**_____

Occupation_____ **Employer's Name**_____

Single / Married / Divorced / Widowed **Spouse's Name**_____

Number of Children_____ **Names (if in-home, list age)** _____

Who may we thank for referring you? _____

List The Health Concerns That Brought You Into This Office

Health Concerns: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had this problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	C I
Second:_____	_____	_____	_____	_____	C I
Third:_____	_____	_____	_____	_____	C I
Fourth:_____	_____	_____	_____	_____	C I

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? □ **YES** □ **NO**

IF YES: □ **CHIROPRACTOR** □ **MEDICAL DOCTOR** □ **OTHER**_____

WHO AND WHEN?_____ **RESULTS?**_____

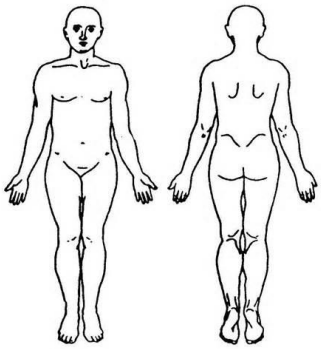
PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE:

__ *Headaches*	__ *Ear Infections*	__ *Sinus Issues*	__ *Kidney Problems*	__ *Sexual Dysfunction*
__ *Migraines*	__ *Hearing Loss*	__ *Frequent Colds*	__ *Bladder Problems*	__ *Sleep Problems*
__ *Jaw/TMJ Pain*	__ *Ringing in the Ears*	__ *Thyroid Issues*	__ *Menstrual Problems*	__ *Tight/Sore Muscles*
__ *Neck Pain*	__ *Dizziness*	__ *Asthma*	__ *Prostate Problems*	__ *Sports Injury*
__ *Shoulder Pain*	__ *Loss of Energy*	__ *Chest Pain*	__ *Infertility*	__ *Sciatica*
__ *Arm Pain*	__ *Nervousness*	__ *Heart Problems*	__ *Fibromyalgia*	__ *Arthritis/Joint Pain*
__ *Upper Back Pain*	__ *Double/Blurry Vision*	__ *Nausea*	__ *Epilepsy/Convulsions*	__ *GERD/Gastric Reflux*
__ *Mid Back Pain*	__ *Anxiety*	__ *Ulcers*	__ *Numb/Tingling Arms/Hands*	__ *Tremors*
__ *Lower Back Pain*	__ *ADD/ADHD*	__ *Digestive Issues*	__ *Numb/Tingling Legs/Feet*	__ *Disc Problems*
__ *Hip/Leg Pain*	__ *Loss of Balance*	__ *Diarrhea*	__ *Scoliosis*	__ *Stomach Problems*
__ *Knee Pain*	__ *Depression*	__ *Constipation*	__ *Poor Posture*	__ *High/Low Blood Pressure*
__ *Foot Pain*	__ *Allergies*	__ *Bed Wetting*	__ *Skin Problems*	__ *Difficulty Breathing*

Other: _____

PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE:

__Pregnant **__Stroke** **__Cancer** **__Heart Attack** **__Spinal Surgery** **__Spinal Bone Fracture**
__Diabetes **__Arthritis** **__Seizures** **Other:**_____



**PLEASE MARK the areas on the diagram with the LETTERS to describe your symptoms:*

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What makes your symptoms better/worse: _____

SOCIAL HISTORY

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

List all over the counter & prescription medications you are on and reason for each:

_____

When was your last auto accident? _____

Have you ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

Other trauma:_____

LIST YOUR CURRENT HEALTH GOALS BELOW

HEALTH GOAL	*DATE TO ACCOMPLISH*	*SIGNIFICANCE OF GOAL*
Ex: Get rid of my headaches	*1/1/2016*	*I want to play with my kids*
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked.

If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each.

EXAMPLE: (No pain) 0 1 2 3 (4) 5 6 (7) 8 9 10 (Worst possible pain)

1. How would you rate your pain RIGHT NOW?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2. What is your typical or AVERAGE pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3. What is your pain level at its BEST?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
4. What is your pain level at its WORST?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

OFFICE ONLY:

Q1____+Q2____+ Q4____=____ /3x10=____ (Low Intensity = <50; High Intensity = >50)

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	**EFFECT:**			
Carrying Groceries	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	❑ **Unable to Perform**
Sit to Stand	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Climbing Stairs	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Pet Care	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Driving	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Extended Computer Use	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Household Chores	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Lifting Children	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Dressing	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Shaving	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Sleep	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Static Sitting	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Static Standing	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Walking	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Washing/Bathing	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Sweeping/Vacuuming	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Dishes	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Laundry	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Yard work	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Garbage	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Concentration (Reading)	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Other: _____	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Other: _____	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**

PATIENT SIGNATURE **DATE**

X-RAY AUTHORIZATION

X-rays are utilized in this office to help locate and analyze **vertebral subluxations**. Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

As your healthcare provider, we are legally responsible for your chiropractic records. If any necessary x-rays are taken, they will remain in our files. At your request, we will provide you with a copy.

By signing below you are agreeing to the above terms and conditions.

_____ _____

PRINT YOUR NAME HERE **DATE**

_____ _____

SIGNATURE **DATE OF BIRTH**

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Victory Chiropractic.

_____ _____

SIGNATURE **DATE**

CONSENT AND PRIVACY PRACTICES

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health (particularly your spinal health), and will assist in determining if any further examinations or studies are needed. Findings will help us determine any modifications to your care or provide you with a referral to another health care provider.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

(if patient is a minor)
Guardian Signature: _____ Date: _____