



Confidential Patient Information

Date: _____

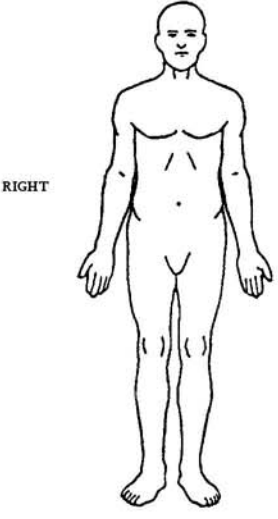
First Name: _____ Last Name: _____ Initial: _____

Major Complaint Information

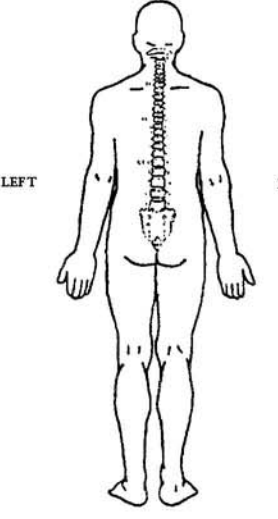
What is your complaint(s)? _____

When did this symptom (s) begin? _____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)



RIGHT



LEFT

RIGHT

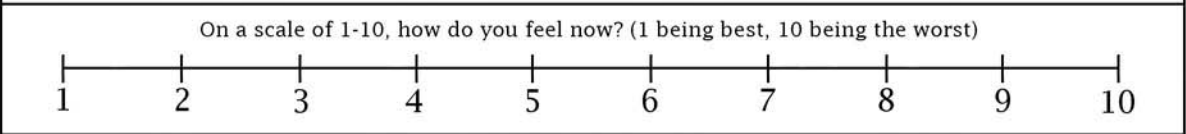
Pain Index

B Burning

S Sharp/Stabbing

Forexample: if you are experiencing moderately severe burning pain in back of you neck, you should note a "B8" on the neck of the illustration.

If this is an injury, describe what happened:



Have you experienced these symptoms before? Yes No When? _____

These symptoms developed from? Auto Accident Work-Related Other: _____

Have you reported this to your: insurance company Yes No employer Yes No

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen a doctor for this condition? Yes No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back Side Stomach

Do you sleep with a pillow? Yes No How many? _____

Does heat affect the pain? Yes No If so, how? _____

Does cold affect the pain? Yes No If so, how? _____

Do you wear a heel lift? Yes No If so, which side? Right Left

Does it cause pain to cough, grunt or sneeze? Yes No If so, where? _____

Check those activities below during which you experience difficulty or pain:

- | | | | | |
|--|--|-----------------------------------|---|---|
| <input type="checkbox"/> Lying on back | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Stooping | <input type="checkbox"/> Standing for periods over one hour |
| <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Gripping | <input type="checkbox"/> Pushing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Climbing | <input type="checkbox"/> Pulling | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Dressing self | <input type="checkbox"/> Reaching | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Walking | |

Fill out the next three sections as they apply to you

Headaches

- Do you have a family history of headaches? Yes No Do you get headaches? Yes No Frequency _____
- Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No
- Abnormal blood pressure? Yes No High Low Nausea, Vomiting or Visual disturbances? Yes No
- When was your last eye exam by a doctor? 1-6 months 6-12 months 1-2 years over 2 years Results: _____

Lower Back Pain

- Do you ever experience ripping or tearing sensations in your back? Yes No If so, where? _____
- Does pain radiate to the abdomen? Yes No
- Do you ever have impairment of bowel or urinary function? Yes No Explain: _____

Neck Pain

- If you have a neck injury, does it effect: (Check all that apply) hearing vision balance cause ringing in your ears
- Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No
- Do you feel ripping or tearing? Yes No Where? _____
- Do you have difficulty lifting or turning your head? Yes No If so, in which direction? Right Left Up Down

If female, are you pregnant? Yes No Not Sure If yes, what is your due date: _____

List all medications you are taking now, including over the counter medication. _____

Are you allergic to any medications: Yes No Not Sure Please list: _____

Have you ever had any surgeries or hospitalizations? Yes No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
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_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? Yes No When?: _____

Have you ever been seen by a chiropractor before? Yes No Please List:

Name of chiropractor:	Dates:	Name of chiropractor:	Dates:
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_____	_____	_____	_____
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Do you have a family physician? Yes No Name of physician: _____ Phone: _____

Address: _____

City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

<input type="checkbox"/> Headache	<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Loss of Concentration	<input type="checkbox"/> Neck Motion Restricted	<input type="checkbox"/> Irritable	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Eyes Sensitive to Light	<input type="checkbox"/> Upper Back Pain/Stiffness	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other (Please List)
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Mid Back Pain/Stiffness	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Heavy Feeling of Head	<input type="checkbox"/> Lower Back Pain/Stiffness	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Right/Left Shoulder Pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Right/Left Arm Pain	<input type="checkbox"/> Flushed Face	<input type="checkbox"/> Convulsions	Please Specify Location:
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Right/Left Leg Pain	<input type="checkbox"/> Excess Perspiration	<input type="checkbox"/> Allergies (Please List)	<input type="checkbox"/> Numbness _____
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Pins & Needles Arms/Legs	<input type="checkbox"/> Digestive Trouble	_____	<input type="checkbox"/> Swelling _____
<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Nausea	_____	<input type="checkbox"/> Cuts _____
<input type="checkbox"/> Pain Behind Eyes	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Vomiting	_____	<input type="checkbox"/> Bleeding _____
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Diarrhea	_____	<input type="checkbox"/> Broken Bones _____
<input type="checkbox"/> Palpitation	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bruising _____
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Heart Disease	

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If so, please list: _____

Any additional information you would like the doctor to know about before beginning care _____

Emergency Contact

Name: _____ Relation: _____
 Home Phone: _____ Work Phone: _____
 Address: _____
 City/State/Zip: _____

Insurance Information

Insurance Company: _____ Phone # _____
 Address: _____
 City/State/Zip: _____
 Insured's Name: _____ Insured's SS# _____ Group # _____
 Insured's Birth Date: _____ Insured's Employer _____

Personal Information

Address: _____
 City/State/Zip: _____
 Home Phone: _____ Work Phone: _____
 Mobile Phone: _____ Pager: _____ Email: _____
 Social Security #: _____ Birth Date: _____ Age: _____ Sex M F
 Drivers License # _____
 Marital Status: S M D W Spouses Name: _____ # of Children: _____
 Occupation: _____ Employers' Name: _____
 Work Address: _____
 City/State/Zip: _____
 How were you referred _____
 Do you have an Attorney? Yes No Name: _____
 Phone #: _____ Address: _____

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at CENTER OF GRAVITY to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of CENTER OF GRAVITY Chiropractic office responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at .

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature:

Date

Parent/Legal Guardian Signature:

Date

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

Second Address: _____

City/State/Zip: _____

Phone: _____

Check months at this address:

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec