Name: _____ Date of Birth: _____ Age: _____
Your Address: _____ City: _____
State: _____ Zip: _____ SS #: _____ Cell #: _____
Name of Employer: _____ Home #: _____
Marital Status: S M W D Email#: _____
How Did You Hear About Us/Who Referred You? _____
How Many Children Do You Have? _____ What Are Their Ages? _____
Have You Or Any Other Members of Your Family Received Chiropractic Care? [ ] Yes [ ] No
How Long Has It Been? _____
Emergency Contact: _____ Phone #: _____
Who Is Responsible For Your Bill? [ ] Self [ ] Spouse [ ] Worker's Compensation [ ] Medicaid
[ ] Medicare [ ] Auto Insurance [ ] Personal Health Insurance [ ] Other: _____
Purpose Or Reason For Today's Appointment?_____
How Often Do You Drink Alcoholic Beverages? _____
Do You Smoke? [ ] Yes [ ]No How Much? _____
Do You Exercise? [ ] Yes [ ]No How Much? _____ Type? _____
Do You have Any Allergies? [ ] Yes [ ] No Specify: _____

Have you Ever Suffered From or Been Diagnosed As Having: (circle yes or no for each)

Y N *Broken or Fractured Bones
Y N Circulatory Problems
Y N Rheumatoid Arthritis
Y N Seizures/Convulsions
Y N A Congenital Disease
Y N Excessive Bleeding
Y N High/Low Blood Pressure
Y N Diabetes
Y N Epilepsy
Y N Pacemaker
Y N Strokes
Y N *Cancer

Y N Ulcers
Y N Ruptures
Y N Coughing Blood
Y N Osteoarthritis
Y N Eating Disorder
Y N Alcoholism
Y N Drug Addiction
Y N HIV Positive
Y N Gall Bladder
Y N *Head Problems
Y N Depression
Y N Tumors

Explain: _____

Healthcare Provider Team

Other providers seen for the same condition:_____

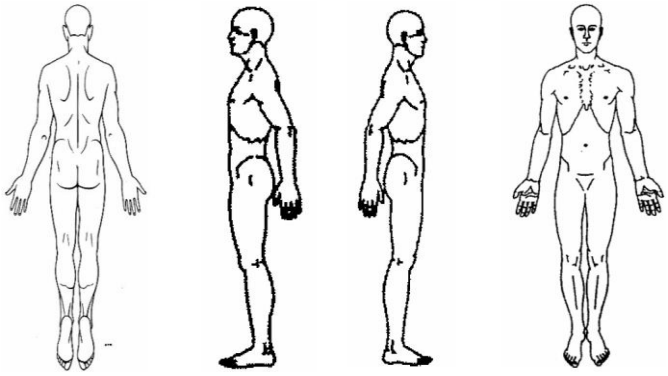
Who is currently your
Chiropractor**:**_____
Primary Care Physician:_____
Physical Therapist: _____
Dentist: _____

Massage Therapist: _____
Personal Trainer: _____
Acupuncturist: _____
Health Club: _____
Other:_____

PATIENT HISTORY

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X. Sharp Pain



	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint	5th Complaint
Complaint:					
When did it start?					
On a scale of 1 -10 1 = mild 5 = moderate 10 = severe Rate your pain levels:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:	Current: Average: At Best: At Worst:
What % of the time does it occur?	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100
When does it occur most?	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____
How long does it last?	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant
What makes it better?					
What makes it worse?					

Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Walking	Y N	Kneeling	Y N	Grooming	Y N	Driving	Y N
Bending	Y N	Sitting	Y N	Standing	Y N	Exercising	Y N
Sleeping	Y N	Lifting	Y N	Running	Y N	Housework	Y N

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1. Have you ever had the condition(s) in the past? [ ] Yes [ ] No
   If yes, please indicate if any treatment was received and what type of treatment:
   [ ] Hospitalization [ ] Chiropractic care [ ]Medical doctor / specialty provider [ ] None
2. Have you ever lost time from work due to your condition(s)? [ ] Yes [ ] No
   If Yes, dates? _____
3. Are you pregnant? [ ] Yes [ ] No
4. What was the first day of your last menstrual cycle? _____
5. Number of pregnancies? _____ Number of miscarriages? _____

Patient Signature: _____ Date: _____

We are excited to offer **Designs for Health** physician-grade supplements in our office! Please place a check next to any of the specific supplements you would like more information about:

____ MULTIVITAMIN

____VITAMIN D

____MAGNESIUM

____ANTI-INFLAMMATORY

____OMEGA/FISH OIL

____CoQ10

____PROBIOTICS

____VITAMIN C

____B VITAMINS

Designs for Health also offers options to support specific conditions. Please place a check next to any of the specific conditions you would like to improve:

____COLLAGEN FOR BONE, JOINT, AND SKIN HEALTH

____DIGESTIVE HEALTH

____SLEEP HEALTH

____STRESS/MOOD SUPPORT

____IMMUNE HEALTH

____WEIGHT LOSS

_____NOT INTERESTED

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic at this office and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic at this office. I have had an opportunity to discuss with the doctor(s) of chiropractic at this office and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Canton Chiropractic and Massage will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Canton Chiropractic and Massage. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____Date: _____

Guardian's Signature: _____ Date:_____