ELEVATE
CHIROPRACTIC

File # _____
Date _____

Personal Information

Patient Name: _____Date:_____
Birthday:_____/_____/_____ Age:_____ Sex:_____ Height:_____ Weight:_____
Address: _____City:_____ State:_____ Zip:_____
Marital Status: □ Single □Married □Divorced□ Widowed □Separated Spouse's Name:_____
Occupation:_____ Employer:_____
Referral Source:_____

Insurance

Insurance Company:_____
Subscriber Name:_____Subscriber DOB: _____/_____/_____`
Insurance ID #: _____ Group/Claim #: _____
Is patient covered by additional insurance (Yes/No) If yes, Name of Insurance Company:_____
Subscriber Name:_____ Subscriber DOB: _____/_____/_____
Insurance ID # :_____ Group/Claim #: _____

Contact Information

Phone Number (Home): _____ (Cell): _____
Parents Name & Cell Phone (if patient is a minor): _____
Email: _____
In case of emergency please contact (Name): _____
Relationship:_____ Phone Number: _____

Chiropractic Case History

What is your major complaint(s)?: _____
What was the initial cause of this complaint?: _____
When did this complaint begin?: _____
Have you ever had this complaint before?:_____
Where is the location of the complaint?: _____
Are you presently under a doctor's care for this complaint? Yes/No
Name of treating doctor:_____
Please circle the quality of the complaint/pain:
Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Other_____
Does this complaint/pain radiate or travel (shoot) to other areas of your body? Yes/No
If so, where to_____

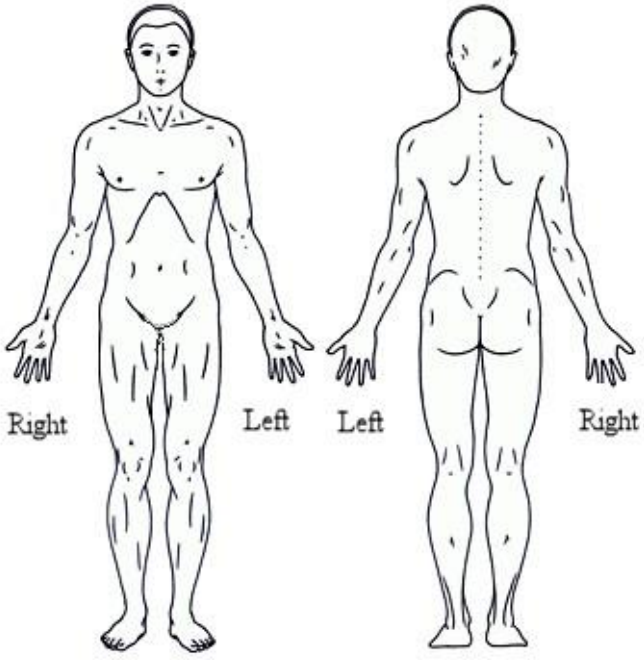
Do you have any numbness or tingling in your body? Yes/No Where? _____
Circle below the severity of your pain:
(No complaint/pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain/complain)

Circle how frequent the complaint presents:
Constant Frequent Occasional
Intermittent Random Other:_____

Does anything aggravate the complaint?:_____

Does anything make the complaint better?
_____

Circle what this complaint interferes with:
Work Home Life Daily Routine
Recreation Sleep Other:_____
Explain:_____
_____



Previous Interventions

What are the treatments, medications, surgery, or care you have sought for your complaint?
_____

Please mark any of the following conditions or symptoms that you have now or have experienced:

- ○ Headaches
- ○ Neck Pain
- ○ Sleeping Problems
- ○ Low Back Pain
- ○ Nervousness
- ○ Tension
- ○ Irritability
- ○ Dizziness
- ○ Pain Between Shoulders
- ○ Stiff Neck
- ○ Loss of Balance
- ○ Ear Ringing
- ○ Jaw/TMJ Problems
- ○ Pain in Hands or Arms
- ○ Numbness in Hands or Arms
- ○ Pain in Legs or Feet
- ○ Numbness in Legs or Feet
- ○ Fatigue
- ○ Depression
- ○ Light Sensitivity
- ○ Memory Loss
- ○ Shoulder Pain
- ○ Allergies
- ○ Cold Hands
- ○ Cold Feet
- ○ Loss of Smell or Taste
- ○ Chest Pain
- ○ High Blood Pressure
- ○ Stroke
- ○ Cancer
- ○ Painful Urination
- ○ Diabetes
- ○ Diarrhea
- ○ Constipation
- ○ Digestive Problems
- ○ Joint Swelling
- ○ Shortness of Breath
- ○ Weight Loss
- ○ Asthma

List previous illnesses you've had in your life **:**

List previous injuries or trauma:

Have you ever broken any bones? Which bones? When did this occur?

List all allergies:

List all medications you are currently taking:

What condition/s you are taking medications for:

Have you had any Surgeries? If so, What kind? What date?

Have you had any Pregnancies? If so, what were was the date of delivery? What were the outcomes?

Social and Occupational History

What is your job description: _____
What recreational activities do you enjoy: _____
Do you take vitamins or supplements? If so, what type and how often:

Do you smoke or drink alcohol? If so, how often (per week):_____
How often do you drink caffeine during the day?:_____

On a scale of 1 – 10. How committed are you to resolving this complaint?: _____
Are there any other health concerns you would like to address?:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me/child with chiropractic care, in accordance with this state's statutes.

Patient Signature _____ Date _____
Parent or Guardian Signature _____ Date _____