

# ***WELCOME TO ULTIMATE HEALTH CHIROPRACTIC***

Please fill out this form as completely and accurately as possible.  
All the information requested below, is necessary for us to serve you the best way possible

Today's Date \_\_\_\_\_

## ***PERSONAL DATA***

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's names (if you are under 18) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ E-mail address \_\_\_\_\_

Business Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

SS# \_\_\_\_\_ Emergency contact & number \_\_\_\_\_

Marital Status S M D W L/W Name of Spouse \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## ***REASON FOR SEEKING CHIROPRACTIC CARE***

What concerns do you feel Ultimate Health Chiropractic can address for you? \_\_\_\_\_

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Recreation:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports	Y	N	Eating:	Y	N	Love life:	Y	N

On a scale of 0-10, rate the level of interference on your quality of life (10 being severe) \_\_\_\_\_

## ***HEALTH CARE PRACTITIONER HISTORY***

Have you ever received Chiropractic care? Y N With whom \_\_\_\_\_

How long under care? \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Was there a particular health concern for which you consulted the chiropractor?

Have you consulted or do you regularly consult any of the following care providers? (check all that apply)

<input type="checkbox"/> Medical Physician	<input type="checkbox"/> Naturopath	<input type="checkbox"/> Acupuncturist	<input type="checkbox"/> Homeopath
<input type="checkbox"/> Massage Therapist	<input type="checkbox"/> Psychotherapist	<input type="checkbox"/> Energy Healer	<input type="checkbox"/> Dentist

Reason why: \_\_\_\_\_

*FOR WOMAN*

Are you pregnant?      Y      N      Date of last menstrual period: \_\_\_\_\_

If x-rays are recommended, your signature is required (below) to indicate that you are not pregnant.

Signature and Date: \_\_\_\_\_

If pregnant, what is due date? \_\_\_\_\_ Name of OBGYN or Midwife \_\_\_\_\_

Where will you be birthing your baby?    Hospital    Home    Birthing Center    Other \_\_\_\_\_

**HEALTH, WELLNESS AND CHIROPRACTIC CARE**

The human body is designed to be healthy. The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae, (bones of the spine) surround and protect the delicate NERVE SYSTEM.

Physical, emotional and chemical stresses, common to our contemporary lifestyles, can result in misalignment to the spinal column as well as damage to the nerve system. The result is a condition called Vertebral Subluxation. (Please see booklet attached). The Chiropractic Exam/evaluation determines if your spine shows signs of the Vertebral Subluxation process.

Please review and indicate your history of “stresses” (below) so that we can assess their relationship to your present health status and examination findings. We will discuss this during the consultation.

*HISTORY OF PHYSICAL STRESSES (Birth to Present)*

**The birth process can traumatize a baby’s spine and cause damage to the nerve system. Please indicate to the best of your recollection where and how you were birthed. (check all that apply)**

**If you do not know, please skip to next question.**

- Home             Natural             Hospital             Caesarian section             Forceps
- Breech             Cord around neck             Prolonged labor             Drug induced labor             Suction

**The information below will help us to see the types of PHYSICAL stresses that you have been subjected to and how they may relate to your present health status.**

Have you had any accidents related to any of the following? (check all that apply)

- Automobile             Motorcycle             Bicycle             Sports             Playground             Abuse

If yes, please explain how and dates: \_\_\_\_\_

Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips)?   Y   N

If yes, please explain how and dates: \_\_\_\_\_

Have you ever broken any bones or sprained any part of your body?            Y   N

If yes, please explain how and dates: \_\_\_\_\_

Have you ever been hospitalized?      Y      N

If yes, please explain how and dates: \_\_\_\_\_

*HISTORY OF CHEMICAL STRESSES*

**Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.**

Were you vaccinated?            Y        N        If yes, did you have a reaction?            Y        N

Have you been exposed to any of the following on a regular basis, (past or present)?

- Toxic chemicals         Drugs (prescribed or not)         Second hand smoke         Other

If yes, please explain: \_\_\_\_\_

Do you have allergies to any foods?    Y            N        **If yes, please describe:** \_\_\_\_\_

\_\_\_\_\_

Please list any prescription medications you are currently taking or have taken in the last year:

**Medications**

**Diagnosis**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any over-the-counter medications you are currently taking or have taken in the last year:

**Product**

**Symptom**

**Quantity & Frequency**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year:

**Product**

**Symptom**

**Quantity & Frequency**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check the following items which apply to you and indicate the amount used:

Coffee	_____	Artificial Sweetner	_____	Ice Cream	_____
Tea	_____	Antacids	_____	Alcohol	_____
Soft Drinks	_____	Laxatives	_____	Cigarettes	_____
Diet Soft Drinks	_____	Candy	_____	Other tobacco products	_____

How many desserts do you have in an average week? \_\_\_\_\_

### *HISTORY OF EMOTIONAL STRESSES*

**It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:**

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

### *QUALITY OF LIFE*

How do you grade your physical health?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How do you grade your emotional/mental health?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How do you rate your overall "quality of life"?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

### *EXPECTATIONS*

As a result of my Chiropractic Care, I would like to: (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Feel better quickly    | <input type="checkbox"/> Have a healthier nerve system     |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Have optimum health on all levels |

*FINANCIAL INFORMATION*

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

Please indicate your method of payment.     Cash     Check     Credit Card

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. If you determine that your insurance covers Chiropractic Care and you would like us to assist you in the billing process, you must **FIRST** fill out an **“Insurance Verification Form”, (IVF)**, to indicate the amount and extent of coverage. Once the IVF is complete, we will gladly submit bills on your behalf.

If you have insurance that will reimburse for Chiropractic services, please indicate the type of policy and name of Insurance carrier:

Health Ins             Auto Accident             Medicare             Worker’s Compensation

Name of Insurance Co: \_\_\_\_\_

If this is an Auto Accident, please provide us with the following information:

Have you been treated elsewhere?    Emergency Room    Primary Care Doctor    Other

What services were provided?         MRI    X-Rays    Medication    Therapy    Other

*The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Brett Wood and Dr. Carolyn Schuster permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any necessary X-rays.*

Signature \_\_\_\_\_ Today’s Date \_\_\_\_\_

Signature of Parent (for minor): \_\_\_\_\_ Today’s Date \_\_\_\_\_

***Thank you for choosing Ultimate Health Chiropractic.  
We look forward to helping you develop a healthier spine and nerve system.***

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