

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? _____

Date symptoms appeared or accident happened: _____

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: _____

Who is your Family Medical Doctor: _____

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: _____

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient _____

Age _____

Check ONE: _____ INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

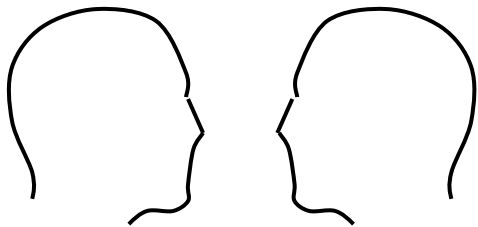
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right

Left

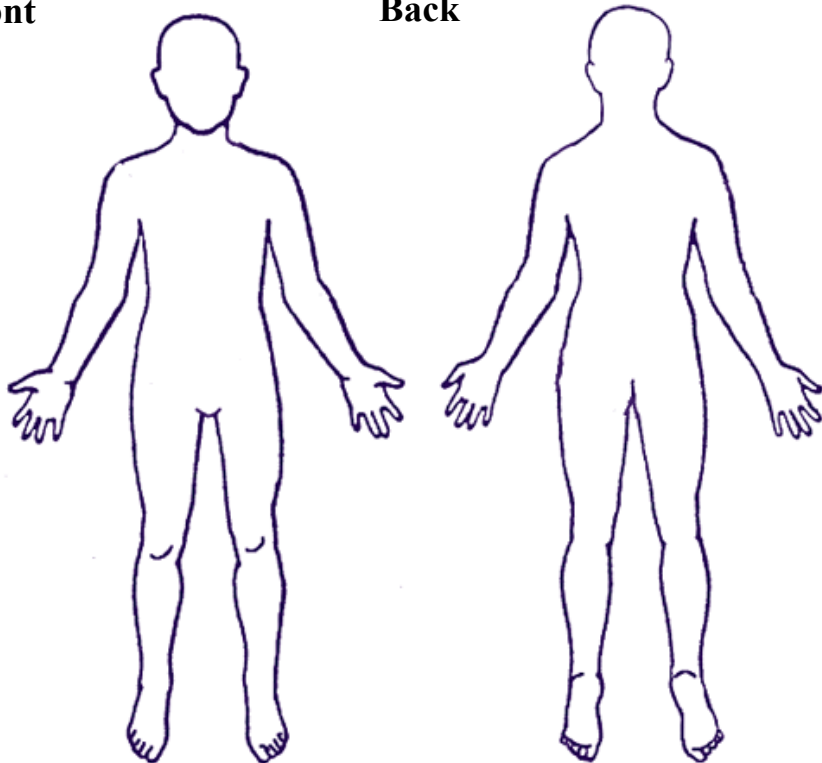


RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

Front

Back



- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+
NONE LITTLE MEDIUM SEVERE EXCRUCIATING

Have you had or do you know have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N= Now

P=Previously

Headaches _____ Frequency _____

Loss of Balance _____

Neck pain _____

Fainting _____

Stiff Neck _____

Loss of Smell _____

Sleeping Problems _____

Loss of Taste _____

Back Pain _____

Unusual Bowel Patterns _____

Nervousness _____

Feet Cold _____

Tension _____

Hand Colds _____

Irritability _____

Arthritis _____

Chest pains/Tightness _____

Muscle Spasms _____

Dizziness _____

Frequent Colds _____

Shoulder/Neck/Arm Pain _____

Fever _____

Numbness in fingers _____

Sinus Problems _____

Numbness in toes _____

Diabetes _____

High Blood Pressure _____

Indigestion Problems _____

Difficulty Urinating _____

Joint Pain/Swelling _____

Weakness in Extremities _____

Menstrual Difficulties _____

Breathing Problems _____

Weight Loss/Gain _____

Fatigue _____

Depression _____

Lights Bother Eyes _____

Loss of Memory _____

Ears Ring _____

Buzzing in Ears _____

Broken Bones/Fractures _____

Circulation Problems _____

Rheumatoid Arthritis _____

Seizures/Epilepsy _____

Excessive Bleeding _____

Low Blood Pressure _____

Osteoarthritis _____

Osteoporosis _____

Pacemaker _____

Heart Disease _____

Stroke _____

Cancer _____

Ruptures _____

Coughing Blood _____

Eating Disorder _____

Alcoholism _____

Drug Addiction _____

HIV Positive _____

Gall Bladder Problems _____

Depression _____

Ulcers _____

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 Sweetener _____	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)

- Feel better quickly
- Have a healthier spine
- Have a healthier nerve system
- 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.***
