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 _____

Cell Phone (____) _____ Cell Phone Provider for Text Reminders_____

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)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ 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_____

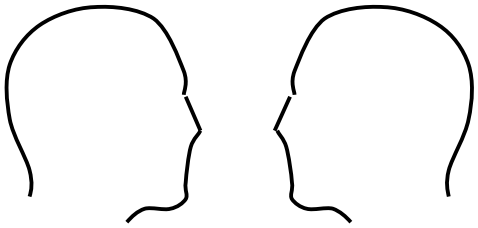
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

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

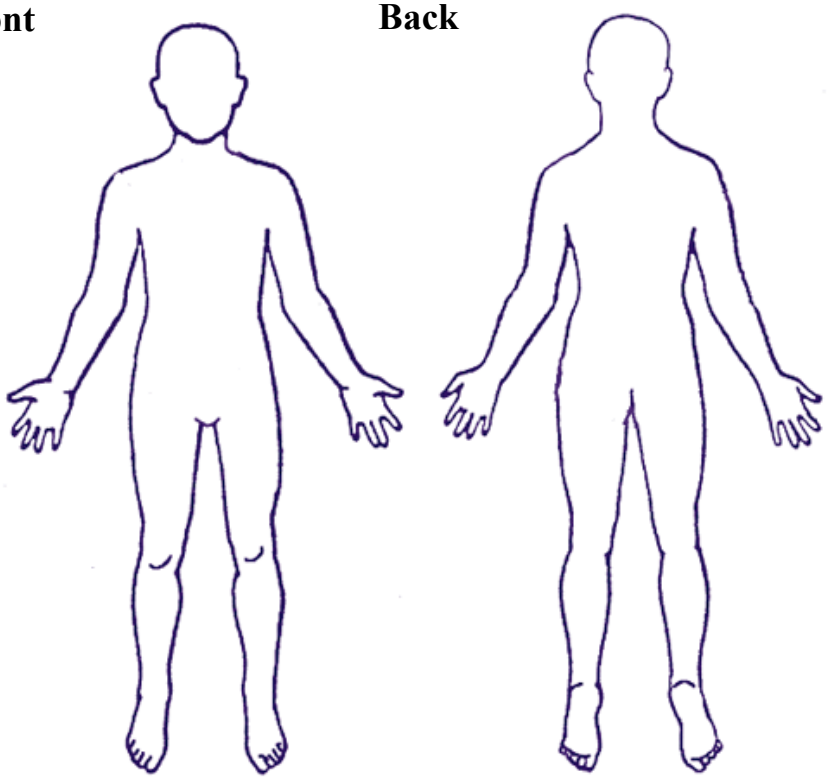
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



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:

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 now 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_____

Neck pain_____

Stiff Neck_____

Sleeping Problems _____

Back Pain_____

Nervousness_____

Tension_____

Irritablity_____

Chest pains/Tightness_____

Dizziness_____

Shoulder/Neck/Arm Pain_____

Numbness in fingers_____

Numbness in toes_____

High Blood Pressure_____

Difficulty Urinating _____

Weakness in Extremeties_____

Breathing Problems_____

Fatigue_____

Lights Bother Eyes_____

Ears Ring_____

Broken Bones/Fractures_____

Rheumatoid Arthritis_____

Excessive Bleeding_____

Osteoarthritis_____

Pacemaker_____

Stroke_____

Ruptures_____

Eating Disorder_____

Drug Addiction_____

Gall Bladder Problems_____

Ulcers_____

Loss of Balance _____

Fainting_____

Loss of Smell_____

Loss of Taste_____

Unusual Bowel Patterns_____

Feet Cold_____

Hand Colds_____

Arthritis_____

Muscle Spasms_____

Frequent Colds_____

Fever_____

Sinus Problems_____

Diabetes_____

Indigestion Problems_____

Joint Pain/Swelling_____

Menstrul Difficulties_____

Weight Loss/Gain_____

Depression_____

Loss of Memory_____

Buzzing in Ears_____

Circulation Problems_____

Seizsures/Epilepsy_____

Low Blood Pressure_____

Osteoporosis_____

Heart Disease_____

Cancer_____

Coughing Blood_____

Alcholoism_____

HIV Positive_____

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? YN **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-coutner 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	_____	Artifical 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? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

EXPECTATIONS

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

❒ Feel better quickly
❑ Have a healthier nerve system
❒ Have a healthier spine
❑ 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 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.