welcome

welcome

“The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease.”
– Thomas Edison

DATE _______________

CONFIDENTIAL PATIENT INFORMATION

THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR CHIROPRACTIC NEEDS. PLEASE COMPLETE THIS FORM IN INK. IF YOU HAVE ANY QUESTIONS OR CONCERNS, DO NOT HESITATE TO ASK FOR ASSISTANCE. WE WILL BE HAPPY TO HELP.

(*PLEASE PRINT*)

NAME ____ SEX: ☐ FEMALE ☐ MALE

ADDRESS ____ CITY ___________________________

POSTAL CODE _________________ HOME PHONE ______________ CELL PHONE _______________

YOUR EMAIL ____

DATE OF BIRTH _______________ AGE ______

EMPLOYER __________________________ OCCUPATION ____________________________________

WHERE DO YOU PREFER TO RECEIVE CALLS? ☐ HOME ☐ WORK

MARITAL: ☐ S ☐ M ☐ D ☐ W ☐ SEPARATED SPOUSE’S/PARENTS’ NAME _____________________

NAMES AND AGES OF CHILDREN ____
(IF APPLICABLE)

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____

PERSON TO CONTACT IN CASE OF EMERGENCY _________________________ PHONE _______________

DO YOU HAVE ADDITIONAL INSURANCE COVERAGE FOR CHIROPRACTIC CARE? ☐ YES ☐ NO

HAVE YOU EVER ATTENDED ANOTHER CHIROPRACTOR? ☐ YES WHEN ________________ ☐ NO

NAME: ____

ABOUT YOUR HEALTH

THE HUMAN BODY IS DESIGNED TO BE HEALTHY. THERE ARE MANY EVENTS THAT OCCUR AS WELL AS HABITS WE DEVELOP THROUGHOUT OUR LIFETIME, THAT INTERFERE WITH OUR ABILITY TO MAXIMIZE THE EXPRESSION OF OUR OPTIMUM HEALTH POTENTIAL. PLEASE TAKE A MOMENT NOW TO ANSWER THE FOLLOWING SIMPLE QUESTIONS SO THAT WE MIGHT BETTER UNDERSTAND YOUR OVERALL HEALTH PICTURE. WE NEED TO DEVELOP AN APPRECIATION FOR THE LAYERS OF DAMAGE THAT MAY EXIST IN YOUR BODY, AND DETERMINE THOSE THAT ARE CONTRIBUTING TO THE BLOCKAGE OF YOUR BODY’S INNATE ABILITY TO BE WELL AND HEALTHY.

SIGNATURE ____ DATE _____________

YMPTOMS AND ILL HEALTH

AS THE YEARS GO BY & THE LAYERS OF DAMAGE INCREASE, IT IS COMMON TO BEGIN TO EXPERIENCE SYMPTOMS AND RANDOM BOUTS OF ILL HEALTH UNTIL WE ARE BROUGHT TO OUR PRESENT STATE OF HEALTH.

PRESENT REASON FOR CONSULTING OUR OFFICE:

_______ CORRECTION AND PREVENTION OF EXISTING PROBLEM?

_______ MAXIMIZING PERSONAL AND/OR FAMILY HEALTH POTENTIAL?

IF YOU HAVE A SPECIFIC CHIEF COMPLAINT, PLEASE DESCRIBE IT BRIEFLY.

____

____

HOW AND WHEN DID THIS PROBLEM START? ____

____

DOES THE PAIN RADIATE OR TRAVEL ANYWHERE ELSE? ☐ YES ☐ NO
IF SO, WHERE? ____

IS THE PROBLEM .... ☐ CONSTANT ☐ INTERMITTENT ☐ WORSE WITH MOVEMENT

IS CONDITION WORSE .... ☐ IN THE A.M. ☐ IN THE P.M. ☐ NO CHANGE

IS CONDITION INTERFERING WITH .... ☐ SLEEP ☐ WORK
☐ ROUTINE ☐ OTHER

IS CONDITION GETTING PROGRESSIVELY WORSE? ☐ YES ☐ NO

TYPE OF PAIN: ☐ SHARP ☐ THROBBING ☐ NUMBNESS ☐ ACHING ☐ SHOOTING
☐ DULL ☐ SWELLING ☐ STIFFNESS ☐ BURNING ☐ CRAMPS ☐ TINGLING

WHAT AGGRAVATES YOUR CONDITION/PAIN? ___________________________________
WHAT RELIEVES YOUR CONDITION/PAIN? ______________________________________

HAVE YOU HAD THIS PROBLEM BEFORE? ☐ YES ☐ NO
IF THIS CONDITION WAS TREATED IN THE PAST, PLEASE DESCRIBE TREATMENT & RESULTS.

____

____

COULD YOUR PROBLEM HAVE BEEN CAUSED BY AN INJURY AT WORK? IF YES, PLEASE GIVE US THE DETAILS.

____

____

HAVE YOU HAD XRAYS TAKEN OF THIS AREA? ☐ YES ☐ NO
WHEN? ________________ WHERE? ______________________________

HAVE YOU EVER BEEN INVOLVED IN AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO

DATE _______________

ANY DIFFICULTIES/INJURIES ARISING FROM THIS INCIDENT? ___________________________

____

PLEASE LIST ANY ADDITIONAL HEALTH PROBLEMS YOU ARE EXPERIENCING AT THE PRESENT TIME _______

____

HAVE YOU HAD ANY SURGERIES? ☐ YES ☐ NO

IF YES, PLEASE GIVE US A FEW DETAILS ____

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO

IF YES, PLEASE LIST ALL ____

FOR WOMEN ONLY:

DATE OF LAST MENSTRUAL PERIOD ____________

SECONDARY COMPLAINTS?

____

____

____

**** ON A SCALE OF 1 TO 10, WITH 10 BEING THE HIGHEST, RATE YOUR LEVEL OF COMMITMENT IN HELPING US SOLVE THIS PROBLEM _____

DATE ____________ SIGNATURE ___________________________________

PATIENT AUTHORIZATION FORM

TO ____

(NAME OF PHYSICIAN, HOSPITAL OR LABORATORY)

YOU ARE HEREBY AUTHORIZED TO PROVIDE FROM YOUR RECORDS, ANY INFORMATION OR REPORTS CONCERNING THE STATE OF MY HEALTH, WHICH MAY BE REQUESTED BY:

JEFFERY STEWART, DC

3472 ROUTE 130 HARRISON CITY, PA 15636

EMAIL. STEWARTCHIROPRACIC@EC.RR.COM

THANK YOU FOR YOUR COOPERATION. ______________________________

(PATIENT'S NAME)

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