

First Name : \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle : \_\_\_\_\_

Sex : ( )M ( )F DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital status: ( )Single ( )Partnered ( )Married

Number of children: \_\_\_\_\_ How many live with you? \_\_\_\_\_

Occupation is/was: \_\_\_\_\_ Employer: \_\_\_\_\_

Family Medical doctor: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Have you seen a Chiropractor before? ( )Yes ( )No Last Chiropractor: \_\_\_\_\_

Who referred you to Best U: \_\_\_\_\_

### Current Complaints

What is causing you the most discomfort? \_\_\_\_\_

When did this start? \_\_\_\_\_ Was there an accident or injury? \_\_\_\_\_

How bad is this problem? (No pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst pain)

What is causing you the next most discomfort? \_\_\_\_\_

When did this start? \_\_\_\_\_ Was there an accident or injury? \_\_\_\_\_

How bad is this problem? (No pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst pain)

If there are more complaints, please mark here ( ) and describe on the back of this page.

### Health History

Do you have or have you had any of the following? Please circle all that apply.

Blood Pressure issues

Heart issues

Breathing difficulties

Heartburn/acid reflux

Constipation/Diarrhea

Incontinence

Arthritis

Sexual performance issues

Diabetes

Allergies

Thyroid issues

Other (please list on back)

List any allergies: \_\_\_\_\_

List previous injuries/ fractures: \_\_\_\_\_

List previous surgeries/  
hospitalizations: \_\_\_\_\_

Women only:

Are you pregnant? \_\_\_\_\_ No \_\_\_\_\_ Yes/ How long? \_\_\_\_\_

### **Emergency Information**

Who should we contact in case of an emergency? \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

## **TERMS OF ACCEPTANCE & INFORMED CONSENT**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Chiropractic adjustments are a gentle and safe procedure, but like any health care procedure there are inherent risks. Certain conditions involving the vertebral arteries can predispose patients to stroke, so we do our best to screen patients for these conditions. Some other conditions that could lead to injury with chiropractic adjustments are: bone tumors/bone cancers, osteoporosis, osteolytic diseases or unhealed pre-existing fractures.

**The above information is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my medical status.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_