



ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
PLEASE LIST YOUR CHILDREN'S NAME & AGES	
NAME:	AGE:
NAME:	AGE:
NAME:	AGE:
EMPLOYER NAME:	
WORK PHONE:	OCCUPATION:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO/DID YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per day _____
DO/DID YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per week _____
DO YOU DRINK COFFEE, TEA, OR SODA	If yes, how much per day _____
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU WEAR:	
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS	
DO YOU GET RESTFUL SLEEP? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOW MANY HOURS PER NIGHT? _____	
DO YOU TAKE A DAILY VITAMIN OR SUPPLEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> WELLNESS <input type="checkbox"/> OTHER PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

YES NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

YES NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

YES NO

MEDICATIONS YOU TAKE

CHOLESTEROL MEDICATIONS BLOOD PRESSURE MEDICINE

ANTI-DEPRESSANT BLOOD THINNERS

SLEEP AID PAIN KILLERS AND ASPIRIN

MUSCLE RELAXERS OTHER:

INSULIN OTHER:

GOALS FOR YOUR CARE

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Corrective care:** Symptomatic relief of pain or discomfort.
- Relief care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.
- I want the doctor to select the type of care appropriate for my condition.**

Would you like to know more about:

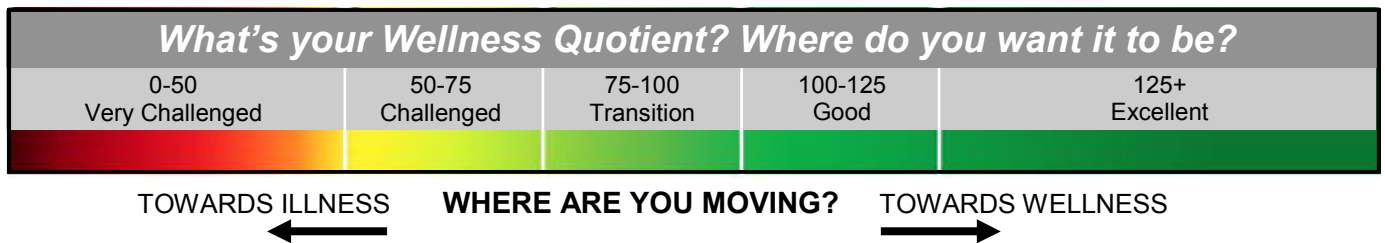
- Proper nutrition, meal planning, vitamins and supplements
- Proper exercise routines and techniques
- How to deal with lifestyle stress

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> SLEEPING PROBLEMS	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> INFERTILITY	<input type="checkbox"/> FATIGUE	FOR WOMEN ONLY:
<input type="checkbox"/> NUMBNESS/TINGLING	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> ANXIETY	<input type="checkbox"/> ALLERGIES	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOW BACK PAIN	<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> MID BACK PAIN	<input type="checkbox"/> HEADACHES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> IRRITABILITY	<input type="checkbox"/> DIABETES	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BREATHING PROBLEMS	<input type="checkbox"/> COLD HANDS/FEET	<input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEARTBURN	<input type="checkbox"/> CONSTIPATION	<i>DO YOU:</i> EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> MENSTRUAL PAIN/ IRREGULARITY	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	

Your *Wellness Quotient* is a number on a scale from 0-200 and is based on your current lifestyle choices-how and what you are eating, your sleep and exercise habits, etc. **INSTRUCTIONS:** On the chart below, mark an "x" where you think your current *Wellness Quotient* is and mark an "O" where you want to be.



The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Print Name _____

Signature _____

Date _____

TERMS OF ACCEPTANCE

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

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 to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

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 evaluation, 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 who 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 subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Please Print)

Relationship to Patient (If Patient is a Minor)

Signature

Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and associates of Swenson Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature

Date