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Healthy Day Chiropractic

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About the Patient

Name: _____ Today's Date: _____ Birthday: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Gender: ☐ M ☐ F
Significant Other's Name: _____ Kid's Names and Ages: _____
Your Employer: _____ Type of Work: _____
Email Address: _____ Have you been to a chiropractor before? ☐ No ☐ Yes
Emergency Contact: _____ Home Phone: _____ Cell Phone: _____
Name of Medical Doctor(s): _____ Referred By: _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I authorize Healthy Day Chiropractic to release and/or request records to or from other providers as may be necessary
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Insurance

_____ _____
Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

Reason for Seeking Care

Present Complaints

1. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the Same ☐ Getting Worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the Morning ☐ Worse in the evening ☐ Pain Radiates to _____

2. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the Same ☐ Getting Worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the Morning ☐ Worse in the evening ☐ Pain Radiates to _____

3. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the Same ☐ Getting Worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the Morning ☐ Worse in the evening ☐ Pain Radiates to _____

4. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the Same ☐ Getting Worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the Morning ☐ Worse in the evening ☐ Pain Radiates to _____

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

6. What makes it better? _____
7. What makes it worse? _____
8. What Doctor's have you seen for this? _____
9. Type of treatment? _____
10. Results _____
Notes: _____

Are you pregnant?
☐ No ☐ Yes

Mark *ALL* areas of concern