Naturally Chiropractic Family Wellness Center

Today's Date:_____

Name:_____ F M Age:___ Birthdate:_____ SS #:_____

Mailing Address:_____ City:_____ Zip:_____

Phone #:_____ Cell#_____ E-mail_____

Marital Status: M S D W Spouse/Guardian's Name:_____ Birthdate:_____ SS #:_____

Number of Children:_____ Ages of Children:_____

Your/Guardian's Occupation & Employer:_____

Work Phone #:_____ Is it OK to Call at Work? Y N

Spouse's Occupation & Employer:_____

What brings you to our office today?_____

Were you injured at work or in an automobile accident? Y N If yes, please give date of injury:_____

How did you hear about our office?_____

CONSENT TO TREAT A MINOR CHILD: (If applicable)

I, the undersigned, the parent or legal guardian of the above named child, hereby authorize the doctor(s) of Naturally Chiropractic Family Wellness Center, or whomever they delegate, to examine, and/or treat the above mentioned child, within the scope of Chiropractic examination and treatment guidelines. I have had any questions or concerns addressed to my satisfaction.

_____ _____ _____

Signature Printed Name Date

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WHY THIS FORM IS IMPORTANT:

As a full spectrum Chiropractic office, we focus on your ability to be healthy & active. Our goals are, first to address the issues that brought you here & second, to offer you the opportunity of improved health potential & wellness services for you & your family in the future. We face chemical, physical & emotional stresses on a daily basis . Most times, effects are gradual & are not even felt until they become serious. Please answer the following questions as completely as possible allowing us to better sees the challenges to your health potential.

- List any complications during or after **your own** birth. (Include forceps, Caesarian, vacuum extraction or induction)

_____

- List any significant childhood illnesses/surgeries, physical or emotional trauma or prolonged medication used.

_____

- Check any of the following health challengers you have faced in the past 5 years (CIRCLE CURRENT ISSUES):

__Headaches	__Numbness/Tingling in limb(s)	__Sleeping problems	__Digestive/Bowel Issues
__Depression	__High Stress (personal/job)	__Emotional Trauma	__Beck/Neck Pain
__Physical Trauma	__Kidney/Bladder/Prostrate Issues	__Menstrual/Hormonal Issues	__Pain in Limb(s)
__Surgery	__Dizziness/Passing out	__Poor Diet/Exercise	__Severe Health Problems

_____

_____

_____

- List any medications you are currently taking (prescription and over the counter) & what they are for:

_____

- **Females only:** Are you, or could you be pregnant? Y N
- Have you been under Chiropractic care before? Y N If so, when and by whom were you last adjusted?_____
- **What result applies best to the level of care you are hoping to obtain from our office?**

___RELIEF -Relief from pain & symptoms to be more comfortable

___CORRECTION -Going beyond relief from pain & correcting the problem at its source

___WELLNESS -To become healthier, focusing on vitality & wellness

I herby certify that the information given on this form is true to the best of my knowledge. I agree to allow this office and its designated staff to perform an assessment and/or treatment on me. I understand that, regardless of any expected insurance contribution or settlement, I am ultimately responsible for any charges I incur at this office.

Signature_____Printed Name_____Date_____