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's Name: _____ Birthdate: _____ SS #: _____

Number of Children: _____ Ages of Children: _____

Your 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

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 <u>your own</u> 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	__Back/Neck Pain
__Physical Trauma	__Kidney/Bladder/Prostrate Issues	__Menstrual/Hormonal Issues	__Pain in Limb(s)
__Surgery	__Dizziness/Passing out	__Poor Diet/Exercise	__Severe Health Problem:

_____

_____

_____

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

_____

- <u>Females only:</u> 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? _____
- <u>What result applies best to the level of care you are hoping to obtain from our office?</u>

___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 _____