

## Affinity Chiropractic Welcome Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Gender: M or F Birthdate: \_\_\_\_\_

Social Sec. # \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (h) \_\_\_\_\_

9. Have you been to a chiropractor before?  yes  no

If yes, who and date of last visit: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear of our office?

10. What other treatments have you tried?

Reason for today's visit: \_\_\_\_\_

11. Name any health concerns that you have not previously described.

If in pain:

1. Location: \_\_\_\_\_

12. List all medications (prescription and OTC) and supplements you currently take.

2. When did it happen? \_\_\_\_\_

3. Describe the pain (ex. sharp, achy, dull, radiating, constant) \_\_\_\_\_

4. What makes it better? \_\_\_\_\_

13. List all previous surgeries and dates:

5. What makes it worse? \_\_\_\_\_

6. On a scale between 1-10, what does the pain rate as? \_\_\_\_\_

7. Does the pain interfere with (check all that apply)

14. Falls/Accidents/Sports Injuries and dates:

sleeping  work  family life

daily activities  exercise

other (specify) \_\_\_\_\_

8. What have you done to try to help? (check all that apply)

15. On a scale of 1-10, what is your stress level?  Personal  Occupation

ice  heat  exercise

16. On a scale of 1-10, rate the following areas of your life, 10 being excellent

pain relievers  massage

vitamins  stress reduction

Diet  Rest  Exercise

stretching  other

Outlook on life

On a scale from 1-10, how committed are you to resolving this issue? \_\_\_\_\_

On a scale from 1-10, how committed are you to obtaining optimal health? \_\_\_\_\_

Please check all the conditions you have had in your past health history:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headaches/Migraines        | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> HIV               |
| <input type="checkbox"/> Low Back Pain              | <input type="checkbox"/> Loss of taste   | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Neck Pain                  | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Chest Pain        |
| <input type="checkbox"/> Neck Stiffness             | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Buzzing in Ears            | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Extremity Problems         | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Hypo/hyperglycemia         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Auto-Immune Ds.   |
| <input type="checkbox"/> Food Allergies             | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Pin and Needles            | <input type="checkbox"/> Heart burn      | <input type="checkbox"/> Problem Urinating |
| <input type="checkbox"/> Numbness                   | <input type="checkbox"/> Stomach Upset   | <input type="checkbox"/> Mood Swings       |
| <input type="checkbox"/> Lack of Concentration      | <input type="checkbox"/> Tension         | <input type="checkbox"/> Hot Flashes       |
| <input type="checkbox"/> Sensitivity to light/sound | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Menstrual Pain    |
| <input type="checkbox"/> Menstrual Irregularity     | <input type="checkbox"/> Nervousness     | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Environmental Allergies    | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Fatigue           |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Fever           |  |
| <input type="checkbox"/> Loss of Smell              | <input type="checkbox"/> Cold Sweats     |  |

### **Family Health History**

Please list any person in your immediate family (parents, grandparents, or siblings) who suffer from any of the following conditions:

Cardiovascular disease \_\_\_\_\_

Auto-immune disease \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Mental afflictions \_\_\_\_\_

Arthritides \_\_\_\_\_

*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.*

*I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.*

*I understand that I am ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Authorization for Care of a Minor**

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter. I clearly understand that I am personally responsible for payment of all fees charged by this office.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_