Walk CHIROPRACTIC Massage & Acupuncture

Date:___________________

Patient Demographics

First Name:________________________ Last Name:_______________________________________ MI:______

DOB:________/_________/__________ Age:___________ Gender: M / F

Marital Status:______________________ #of Children:___________

Address:____ PO Box #_________

City:____ State:___________________ Zip:___________________

Cell Phone:______________________________________ Home or Work Phone:_____________________________

E---Mail:____

Please Circle Your Preferred Method of Contact: cell # / home # / work # / e-mail / text / mail

Whom or What May We Thank For Your Referral?____

Employment Information

Employer Name:_____________________________________

Work Phone:_____________________ Extension:____________ Professional Title:________________________

Emergency Contact

Contact Name:___________________________ Relationship to Patient:___________________________

Home Phone:_____________________ Cell Phone:_____________________ Work Phone:___________________

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Accident Information

Is your condition due to an Auto or Work Accident? Yes / No **Date of Accident:**____________________

To whom have you made a report of your accident? Auto Ins. / Employer / Work Comp. / Other__________

Primary Insurance Information

Primary Insurance Company:____

Insurance ID #:_____________________ **Group #:**_____________________ **Plan Name:**________________

Secondary Insurance Information

Secondary Insurance Company:____________________________________

Insurance ID #:_____________________ **Group #:**_____________________ **Plan Name:**________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with________________________ and assign directly to Walk Chiropractic & Acupuncture, Inc. for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:____

Relationship:_________________________________ Date:____________________________

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Current Condition

Reason(s) for visit: Chiropractic / Acupuncture / Chiropractic & Acupuncture / Massage / Not Sure

1)____

2)____

3)____

When did symptom(s) first appear?____________________ **and is the condition getting:** better / worse / same

How often do you have these symptom(s)?__________________________**and are they:** constant / come and go

What do you contribute to the condition(s)?__________________________________

This condition interferes with: work / sleep / daily routine / recreation / other____________________________

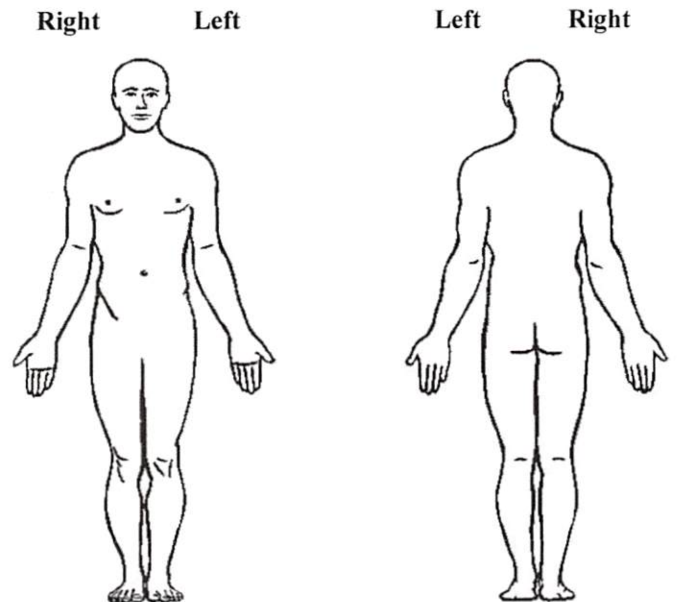
Aggravating or painful activities: sitting / standing / walking / bending / lying down / twisting / other__________

Using the legend below, mark the body diagram where you have any symptoms & rate the intensity of the pain next to each marked location.

Pain Intensity rates from: 0,1,2,3,4,5,6,7,8,9,10 where 0 = no pain and 10 = worst pain imaginable

^^^ Aches
ooo Numbness
Pins/Needles
xxx Burning
/// Stabbing

``` Sharp




**What treatments have you already tried for your condition?** Medications / Surgery / Physical Therapy /

Chiropractic / Acupuncture / Massage / Nutrition / None / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Health History

Please circle all symptoms you had or have and explain below: Where/When/How/What etc...

1) Cold hands
2) Cold feet
3) Constipation
4) Depression
5) Diarrhea
6) Dizziness
7) Fainting
8) Fatigue
9) Headaches
10) Heartburn
11) Hot flashes
12) Irritability
13) Lights bother eyes
14) Loss of balance
15) Loss of smell
16) Loss of taste
17) Menstrual irregularity
18) Menstrual pain
19) Mood Swings
20) Nervousness
21) Numbness in fingers
22) Numbness in toes
23) Pins and needles in arms
24) Pins and needles in legs
25) Ringing in ears
26) Sleeping problems
27) Stomach upset
28) Ulcers
29) Urinary problems
34) Other. List below...

____

____

____

If you take medications, what are you taking and why?

____

Have you had any surgery?

1. Type ____________________ Date: __________ Doctor ____________
2. Type ____________________ Date: __________ Doctor ____________
3. Type ____________________ Date: __________ Doctor ____________

Accidents / Injuries / Illness: (auto, work related, falls, head injuries, childhood illness, etc...)

1. Type ____________________ Date: __________ Hospitalized? Yes / No
2. Type ____________________ Date: __________ Hospitalized? Yes / No
3. Type ____________________ Date: __________ Hospitalized? Yes / No

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Health History Cont…

Have you ever had: X-Rays / MRI / CT Scans? Yes / No

(If Yes) Please Explain:____

Please List Any Allergies Here:____

Do you wear orthotics or heel lifts? Yes / No **Do You Smoke?** Yes / No Quantity: ________________

Sleeping Questions: **Position:** Side / Belly / Back **Hours of Sleep:**__________

Does pain wake you at night? Yes / No **Quality of Sleep:** Excellent / Good / Fair / Poor

Mattress: Years Old:____________ Soft / Medium / Firm

Height:__________ **Weight:**__________ **Are or could you be pregnant?** Yes / No **Due date:**________________

Please Briefly Describe Your Exercise: (What, How Long, How Far, etc…)____________________________________

____

Please list any supplements you consume and why:

____

Please RANK the following from: 1,2,3,4,5,6,7,8 where 1 = LEAST consumed and 8 = MOST consumed:

[ ]Fruits [ ]Veg. [ ]Meat [ ]Water [ ]Dairy [ ]Grains [ ]Sweets [ ]Caffeine

Have you ever had (please circle all that apply): Chiropractic Care / Acupuncture / Massage

I would like to have (circle all that apply):

1.) pain and symptom relief 2.) the cause of the problem corrected 3.) optimal health and wellness