ABOUT THE PATIENT

Alter Chiropractic, Delray Beach, FL 33445

Name _____ Date of Birth: _____ Age: _____ Today's Date_____

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 _____

E-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Alter 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?_____

_____ _____

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

REASON FOR SEEKING CARE

LIST AREAS OF CONCERN:

1. _____ When did it start? _____

Describe: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing Severity: ❑ Mild ❑ Moderate ❑ Severe

How often? ❑ Constant ❑ Comes and goes Pain radiates (travels) to: _____

What makes it better? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

What makes it worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

Treatments you have already had for this? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ _____

2. _____ When did it start? _____

Describe: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing Severity: ❑ Mild ❑ Moderate ❑ Severe

How often? ❑ Constant ❑ Comes and goes Pain radiates (travels) to: _____

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Treatments you have already had for this? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ _____

3. _____

When did it start? _____

Describe: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing

Severity: ❑ Mild ❑ Moderate ❑ Severe

How often? ❑ Constant ❑ Comes and goes

Pain radiates (travels) to: _____

What makes it better? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending

❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

What makes it worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending

❑ Lying Down ❑ Ice ❑ Heat ❑ Medicine ❑ _____

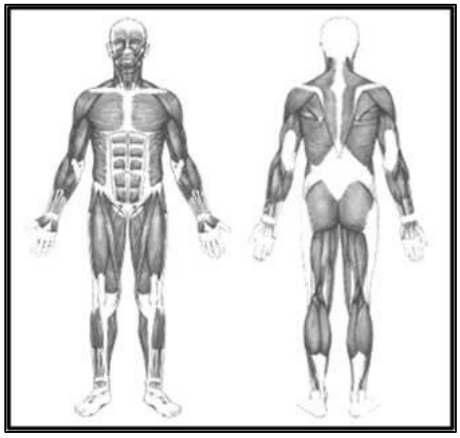
Treatments you have already had for this?

❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic ❑ _____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



GENERAL HEALTH HISTORY

Alter Chiropractic, Delray Beach, FL 33445

Patient Name_____

Mark only the conditions that apply to you:

Past	Present		Past	Present	
☐	☐	Aids / HIV	☐	☐	Kidney Disease
☐	☐	Anemia	☐	☐	Liver Disease
☐	☐	Arthritis	☐	☐	Migraines / Headaches
☐	☐	Asthma	☐	☐	Multiple Sclerosis
☐	☐	Breast Lump	☐	☐	Osteoporosis
☐	☐	Cancer	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Parkinson's disease
☐	☐	Emphysema	☐	☐	Pinched Nerve
☐	☐	Epilepsy	☐	☐	Prostate Problem
☐	☐	Gout	☐	☐	Prosthesis
☐	☐	Heart Disease	☐	☐	Rheumatoid Arthritis
☐	☐	Hepatitis	☐	☐	Stroke
☐	☐	Hernia	☐	☐	Thyroid
☐	☐	Herniated Disc	☐	☐	Other: _____
☐	☐	High Cholesterol	☐	☐	Other: _____

EXERCISE: ❑ None ❑ Moderate ❑ Daily ❑ Heavy ❑ Cardio ❑ Weights ❑ Other _____

WORK ACTIVITY : ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

STRESS LEVEL: ❑ Low ❑ Average ❑ High ❑ Very High **Why**: _____

HABITS: ❑ Smoking ___ Packs / day ❑ Alcohol ___ Drinks / week ❑ Caffeine ___ Cups / Day

MEDICATIONS: _____, _____, _____, _____, _____

PAST HISTORY

Injuries / Surgeries you have had **Description / Approximate Date**

Falls: _____

Broken Bones: _____

Surgeries: _____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

ACCIDENT INFORMATION

Is this condition due to an accident? □ Yes □ No Date: _____

Type of Accident: □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Worker Comp □ Other