Welcome to Crossroads Chiropractic Lakeside

Today's Date:____/____/____
Home Phone #:_____Cell Phone #:_____Work Phone #: _____
Full Name:_____ Nickname:_____
Legal Address:_____
City:_____State:_____Zip Code:_____
Mailing Address: _____
City:_____State:_____Zip Code:_____
Birthdate:____/____/____ Age:_____ Email:_____
How did you learn about our office?_____
Previous Chiropractic Care? _____Yes _____No Approximate Last Visit Date:_____
Status: *(Please Circle)* Single Married Divorced Separated Widowed Domestic Partner
Spouse or Partner's Name:_____
Name and Ages of Children:_____
Hobbies:_____
Patient's Employer/Business:_____ Occupation:_____
Are you seeking care for a work related injury? *(Circle one)* Yes No Auto Accident? *(Circle one)* Yes No

I hereby authorize the doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, full explanation of the procedures involved will be given. I agree to pay all services rendered in this office.
Signature:_____ Date:____/____/____ Relationship to patient:_____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. If eligible, I accept chiropractic care on this basis. I hereby attest to the fact that the above information is true and accurate.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____
Reviewed by: Doctor's Signature Date Form Reviewed

Crossroads Chiropractic Privacy Authorization

We strive to make your experience with us exceptional. However, due to laws passed to protect your privacy we request in writing your authorization to proceed with certain office practices. Your signature below will verify that (1) you have read the following procedures and do not object and (2) you have been given a notice of our privacy practices and an opportunity to review them.

* We use postcards to wish you happy birthday, welcome you or remind you of an appointment
* We may mail health articles, newsletters and other information directly to your home or email
* We may leave a message at your home with someone or on an answering machine
* We post pictures of our "Chiropractic Kids" in the kid's area & "Chiropractic Families" on the Family boards
* Should you share a written testimonial with us, we may display it in binders or use it in our advertising
* You will receive your chiropractic adjustments in an open adjusting area with half walls.

Signature:_____ Date: ___/___/___

Please check reasons for pursuing chiropractic care:

___ *I'm continuing ongoing care from another chiropractor.*
___ *I'm interested in wellness and natural health care.*
___ *I want to improve my immune function.*
___ *I have no idea why I'm here. Please take the time to explain to me what you do.*
___ *I'm concerned about my health and I'm looking for answers.* Explain condition(s) or symptom:

*1.*_____
*2.*_____
*3.*_____
*4.*_____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c*ircling the number* (If applicable):

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last?

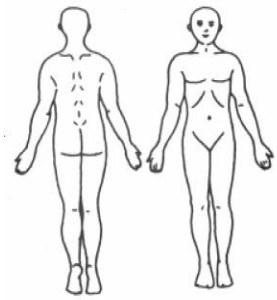
☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

List Prescription or Over-The-Counter Medications now taken: _____

_____

Known Allergies: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times?

_____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____

_____, and who provided it: _____ **How long ago? _____**

What were the results? ☐ Favorable ☐ Unfavorable→ please explain.

Please identify any and all types of jobs you have had in the past that have imposed any physical stress and/or emotional on you or your body:_____

If you have ever experienced any of the following body signals or conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never*** *have had***:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___Disability ___Cancer
___ Dizziness or Fainting ___ Headache ___ Postural Imbalance ___ Arthritis ___ Asthma ____PMS
___ Short Leg/Orthotics ___ Ear Infection ___ Intestinal Problems ___ Frequent Colds ___ Sinus Problems
___ High Blood Pressure ___ Bladder Problems ___ Kidney Problems___ PMS ___ Menopausal Symptoms
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions (list)

PLEASE identify ALL PAST and any **CURRENT** conditions:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect these? _____

_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the following condition(s)? (check any that apply)
__ AIDS __ Alcoholism __ Cancer __ Diabetes __ Epilepsy __ Hyper/Hypothyroidism __ Heart Disease __ Lung Disease __ Multiple Sclerosis __ Scoliosis __ Stroke __ Ulcers ___ OTHER(list):_____

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ offspring
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____