CROSSROADS CHIROPRACTIC Bedford

Today's Date:____/____/____

Home Phone #:_____Cell Phone #:_____Work Phone #: _____

Full Name:_____What do you prefer to be called?:_____

Legal Address:_____

City:_____State:_____ Zip Code:_____

Mailing Address (*if different than above)*: _____

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 she 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?_____

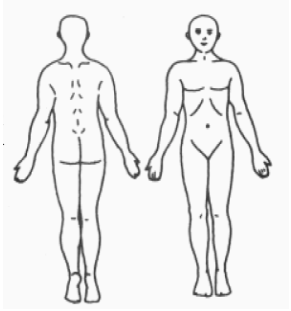
□ It is constant **OR** □ I experience it on and off during the day **OR** □ It comes and goes throughout the week

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 for 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 ___ Ear Infection ___ Intestinal Problems ___ Frequent Colds
___ Sinus Problems ___ High Blood Pressure ___ Heart Attack ___ Bladder Problems ___ Diabetes
___ Kidney Problems ___Osteo Arthritis ___ Cerebral Vascular ___Menopausal Symptoms
___ Short Leg/Orthotics ___ 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 ❑ brother ❑ 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: _____

Thank you!