Peace
Chiropractic Clinic

www.peacechiro.com

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (Or Initial)

Birth Date (MM/DD/YYYY)

Height

Address

Marital Status
◯ Single ◯ Married
◯ Divorced
◯ Widowed ◯ Separated

Weight

City

State

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Spouse's Birth Date

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Your Occupation

Your Employer

Child's Name & Age

Primary Physician

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

CONFIDENTIAL HEALTH INFORMATION

Peace Chiropractic Clinic

A B C D

EXAM
PATIENT HISTORY

Incident: PI WC Group Cash MC

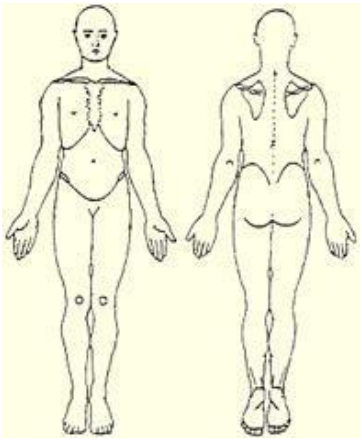
Insurance:_____

_____
Today's Date (MM/DD/YYYY)

_____ _____ _____
Last Name First Name Middle Name (Initial)

1. **What symptoms prompted you to seek care today?**_____

2. **When did these symptoms start? How did they start?**_____



3. **Quality of Symptoms**(What does it feel like?)

◯ Numbness
◯ Tingling
◯ Tightness
◯ Dull
◯ Aching
◯ Cramps
◯ Heavy
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other

4. **Intensity** (How extreme symptoms)
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Absent Uncomfortable Agonizing

5. **Duration & Timing** (how often do you feel it?)
◯Constant ◯ Comes and goes

6. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____

7. **Aggravating or Relieving Factors** (What make it better or worse, such as time of day, movements, activities, etc.)
What tends to lessen the problem?_____
What tends to worsen the problem? _____

8. **Prior Interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Ice
◯ Over-the-counter drugs ◯ Heat
◯ Chiropractic Other_____

9. What else should Envive know about your current condition?_____
_____
_____

10. Review of systems (Identify any changes since your most recent evaluation with us)

		Current	Past	None
a.	**Musculoskeletal System-**osteoporosis, arthritis, neck pain, back problems, poor posture	◯	◯	◯
b.	**Neurological System-**anxiety, depression, headache, dizziness, pins & needles, numbness	◯	◯	◯
c.	**Cardiovascular System**-high blood pressure, low blood pressure, high cholesterol, chest pain	◯	◯	◯
d.	**Integumentary System**-skin cancer, psoriasis, eczema, acne, hair loss, rash	◯	◯	◯
e.	**Genitourinary System**-kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	◯	◯	◯
f.	**Constitutional System**-fainting, low libido, poor appetite, fatigue, sudden weight, weakness	◯	◯	◯
g.	**Lymphatic System**-swelling or pain in lymph nodes of neck, axillae, groin & other areas	◯	◯	◯

11. Prior illnesses, operation, injuries or treatments:_____
_____
_____

12. **Social History** (Tell Envive about your health habits)
Allergies:_____
(203)Tobacco Use:_____

13. Medications/Supplements:_____
_____

14. Goals/Problems_____
_____

POC

NOTE

CODES

CHARGES