

ABOUT THE PATIENT

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender M F
 Significant Other's Name _____ Kids' Names and Ages _____
 Your Employer _____ Type of Work _____
 E-Mail Address _____ Have you been to a chiropractor before? No Yes
 Emergency Contact _____ ph # _____
 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 Campbell 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? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

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

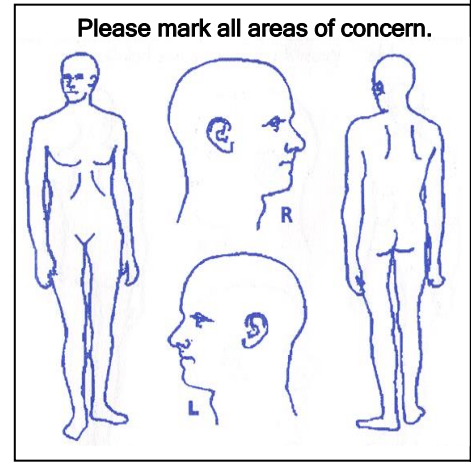
REASON FOR SEEKING CARE

PRESENT COMPLAINTS

- _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____
- _____ How long has this been an issue? _____
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- _____ How long has this been an issue? _____
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- _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____
- Does your condition affect: Sleep Work Daily Routine Sitting Driving
- What makes it better? _____
- What makes it worse? _____
- What Doctor's have you seen for this? _____
- Type of treatment: _____
- Results: _____

NOTES: _____

Are you pregnant?
 Yes No
Are you trying to get pregnant?
 Yes No



GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	Contact Sports
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Concussion(s)
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Whiplash
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to _____	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Labor
<input type="checkbox"/>	<input type="checkbox"/>	Medication Side Effects	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Caesarian Section
<input type="checkbox"/>	<input type="checkbox"/>	Arm / Hand Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinner use	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/ Vertigo
<input type="checkbox"/>	<input type="checkbox"/>	Hands or Feet cold	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Walking	<input type="checkbox"/>	<input type="checkbox"/>	TMJ/ Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Leg / Foot Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure (High/ Low)	<input type="checkbox"/>	<input type="checkbox"/>	Pain all Over
<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Stroke History	<input type="checkbox"/>	<input type="checkbox"/>	Tension / Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	PMS, Irregular, or Painful Cycle			
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems / Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn / Acid Reflux			
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Constipation / Diarrhea / Irregular BM			
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker			
<input type="checkbox"/>	<input type="checkbox"/>	Light Bothers Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Other _____						

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": No Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and 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? _____