**INFORMATION/APPLICATION FOR CARE**

**The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the Chiropractic Assistant. PLEASE PRINT**

**Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age\_\_\_\_\_\_\_\_\_ Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M W D No. of Children \_\_\_\_\_\_\_\_\_\_**

**Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle one payment type: Cash Check Master Card/Visa American Express**

**Your Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years on Job \_\_\_\_**

**Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have Medicare? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_ Medicaid? Yes\_\_\_\_\_ No\_\_\_\_\_**

**Name of Spouse or Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse employed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years on Job \_\_\_\_\_**

**Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_Zip\_\_\_\_\_\_**

**Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your spouse have health insurance at work? Yes \_\_\_\_ No \_\_\_\_**

**COMPLETE THESE DIAGRAMS**

**If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.**

**MAJOR COMPLAINTS**

**(please list any conditions you are being treated for or experiencing.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Referred to our office by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How Payment will be made: Type of Insurance**

**\_\_\_\_\_\_\_\_\_\_\_\_ Cash \_\_\_\_\_\_\_\_\_\_ Workman’s Comp \_\_\_\_\_\_\_\_\_ Health Insurance**

**\_\_\_\_\_\_\_\_\_\_\_\_ Check \_\_\_\_\_\_\_\_\_\_ Credit Card \_\_\_\_\_\_\_\_\_ Automobile Ins. Policy**

**Is your condition due to an accident? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Date of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of accident? Auto \_\_\_\_\_ Work/On Job \_\_\_\_\_ At Home \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been in an Auto Accident? Past Year \_\_\_ Past 5 Years \_\_\_ Over 5 Years \_\_\_ Never \_\_\_**

**I (we) agree to pay for services rendered to the above mentioned patient as the charge Is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, ant fee for professional services rendered me will be immediately due and payable.**

**Patients Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.**

**Insurance Cases: on all insurance assignments the deductible should be met in the beginning unless prior arrangements are made.**

**CONFIDENTIAL PATIENT CASE HISTORY**

***Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU***

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.**

**GENERAL GASTRO-INTESTIONAL CARDIO-VASCULAR**

**\_\_ Allergy \_\_ Belching or gas \_\_ Hardening of arteries**

**\_\_ Chills \_\_ Colitis \_\_High blood pressure**

**\_\_ Convulsions \_\_ Colon trouble \_\_ Low blood pressure**

**\_\_ Dizziness \_\_ Constipation \_\_ Pain over heart**

**\_\_ Fainting \_\_ Diarrhea \_\_ Poor circulation**

**\_\_ Fatigue \_\_ Difficult digestion \_\_ Rapid Heart Beat**

**\_\_ Fever \_\_ Distension of abdomen \_\_ Slow heart beat**

**\_\_ Headache \_\_ Excessive Hunger \_\_ Swelling of ankles**

**\_\_ Loss of sleep \_\_ Gall bladder trouble RESPIRATORY**

**\_\_ Loss of weight \_\_ Hemorrhoids \_\_ Chest pain**

**\_\_ Nervousness/depression \_\_ Intestinal worms \_\_ Chronic cough**

**\_\_ Neuralgia \_\_Jaundice \_\_ Difficult breathing**

**\_\_ Numbness \_\_ Liver trouble \_\_ Spitting up blood**

**\_\_ Sweats \_\_ Nausea \_\_ Spitting up phlegm**

**\_\_ Tremors \_\_ Pain over stomach \_\_Wheezing**

**MUSCLE & JOINT EYES, EARS, NOSE & THROAT SKIN**

**\_\_ Arthritis \_\_ Asthma \_\_ Boils**

**\_\_ Bursitis \_\_ Colds \_\_ Bruise easily**

**\_\_ Foot trouble \_\_ Crossed eyes \_\_ Dryness**

**\_\_ Hernia \_\_ Deafness \_\_ Hives or allergy**

**\_\_ Low back pain \_\_ Dental Decay \_\_ Itching**

**\_\_ Lumbago \_\_ Earache \_\_ Skin Eruptions (rash)**

**\_\_ Neck pain or stiffness \_\_ Ear discharge \_\_ Varicose veins**

**\_\_ Pain between shoulders \_\_Ear noises GENITO-URINARY**

**Pain or numbness in: \_\_ Enlarged Glands \_\_ Bed-wetting**

**\_\_ Shoulders \_\_ Enlarged thyroid \_\_ Blood in urine**

**\_\_ Arms \_\_ Eye pain \_\_ Frequent urination**

**\_\_ Elbows \_\_ Failing vision \_\_ Inability to control kidneys**

**\_\_ Hands \_\_ Far sightedness \_\_ Kidney infection or stones**

**\_\_ Hips \_\_ Gurn trouble \_\_ Painful urination**

**\_\_ Legs \_\_ Hay fever \_\_ Prostate trouble**

**\_\_ Knees \_\_ Hoarseness \_\_ Pus in urine**

**\_\_ Feet \_\_ Nasal obstruction FOR WOMEN ONLY**

**\_\_ Painful tail bone \_\_Near sightedness \_\_ Congested breasts**

**\_\_Poor posture \_\_Nosebleeds \_\_ Cramps or backache**

**\_\_ Sciatica \_\_ Sinus infection \_\_ Excessive menstrual flow**

**\_\_ Spinal Curvature \_\_ Sore Throat \_\_Hot flashes**

**\_\_ Swollen joints \_\_ Tonsillitis \_\_ Irregular cycle**

**\_\_ Menopausal symptoms**

**\_\_Painful menstruation**

**\_\_ Vaginal Discharge**

**\_\_ Y \_\_N Are you pregnant?**

**CHECK THE FOLLOWING CONDITION YOU HAVE HAD:**

**\_\_ Alcoholism \_\_ Cold sores \_\_ Goiter \_\_Miscarriage \_\_Scarlet fever**

**\_\_ Anemia \_\_ Diabetes \_\_ Gout \_\_ Multiple sclerosis \_\_ Stroke**

**\_\_ Appendicitis \_\_ Diphtheria \_\_ Heart Disease \_\_ Mumps \_\_ Tuberculosis**

**\_\_ Arteriosclerosis \_\_ Eczema \_\_ Influenza \_\_ Pleurisy \_\_ Typhoid fever**

**\_\_ Arthritis \_\_ Emphysema \_\_ Lumbago \_\_ Pneumonia \_\_ Ulcers**

**\_\_ Cancer \_\_ Epilepsy \_\_ Malaria \_\_ Polio \_\_Venereal disease**

**\_\_ Chorea \_\_ Fever Blisters \_\_ Measles \_\_ Rheumatic fever \_\_ Whooping Cough**

**PLEASE PRINT**

**What is your major complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List surgical operation and years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Drugs you now take: \_\_ Nerve pills \_\_ Pain killers \_\_ Muscle relaxers**

**\_\_ “Pep” pills \_\_ Tranquilizers \_\_ Birth Control Pills**

**Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age of Mattress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Comfortable \_\_ Uncomfortable \_\_ Do you use a bed board? \_\_\_\_\_\_**

**Are you wearing: \_\_ Heal lifts \_\_ Sole lifts \_\_ Inner soles \_\_ Arch supports**

**Have you been in an auto accident: \_\_Past year \_\_ Past five years \_\_ Over five years \_\_ Never**

**Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any mental or emotional disorders? \_\_ Yes \_\_ No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have others in your family had such disorders? \_\_ Yes \_\_No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU EVER: Yes No DESCRIBE BRIEFLY**

**Been knocked unconscious? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Used a cane, crutch, or other support? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Been treated for a spine or nerve disorder? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Had a fractured bone? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Been hospitalized for anything other than**

**Surgery? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU:**

**Now take vitamins or minerals? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Think you may need vitamins or minerals? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have an allergy to any drug? \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF LAST: Less than 6 months 6-18 months Over 18 months Never**

**Spinal Examination \_\_ \_\_ \_\_ \_\_**

**Physical examination \_\_ \_\_ \_\_ \_\_**

**Blood Test \_\_ \_\_ \_\_ \_\_**

**Chest X-Ray \_\_ \_\_ \_\_ \_\_**

**Spinal X-ray \_\_ \_\_ \_\_ \_\_**

**Dental X-ray \_\_ \_\_ \_\_ \_\_**

**Urine Test \_\_ \_\_ \_\_ \_\_**

**HABITS Heavy Moderate Light None**

**Alcohol \_\_ \_\_ \_\_ \_\_**

**Coffee \_\_ \_\_ \_\_ \_\_**

**Tobacco \_\_ \_\_ \_\_ \_\_**

**Drugs \_\_ \_\_ \_\_ \_\_**

**Exercise \_\_ \_\_ \_\_ \_\_**

**Sleep \_\_ \_\_ \_\_ \_\_**

**Appetite \_\_ \_\_ \_\_ \_\_**

**IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HEALTH HISTORY**

**Many health problems are hereditary in nature and may be handed down generation after generation.**

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please review the below-listed diseases and conditions and indicate these that are current health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climates.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CONDITION** | **FATHER**  **Age ( )** | **MOTHER**  **Age ( )** | **SPOUSE**  **Age ( )** | **BROTHER(s)**  **Age ( )** | **SISTER(s)**  **Age ( )** | **CHILDREN**  **Age ( ) Age ( )** |
| **Arthritis** |  |  |  |  |  |  |
| **Asthma-Hay Fever** |  |  |  |  |  |  |
| **Back Trouble** |  |  |  |  |  |  |
| **Bursitis** |  |  |  |  |  |  |
| **Cancer** |  |  |  |  |  |  |
| **Constipation** |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |
| **Disc Problem** |  |  |  |  |  |  |
| **Emphysema** |  |  |  |  |  |  |
| **Epilepsy** |  |  |  |  |  |  |
| **Headaches** |  |  |  |  |  |  |
| **Heart trouble** |  |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |
| **Insomnia** |  |  |  |  |  |  |
| **Kidney Trouble** |  |  |  |  |  |  |
| **Liver Trouble** |  |  |  |  |  |  |
| **Migraine** |  |  |  |  |  |  |
| **Nervousness** |  |  |  |  |  |  |
| **Neuritis** |  |  |  |  |  |  |
| **Pinched Nerve** |  |  |  |  |  |  |
| **Scoliosis** |  |  |  |  |  |  |
| **Sinus Trouble** |  |  |  |  |  |  |
| **Stomach Trouble** |  |  |  |  |  |  |
| **Other:** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**If any of the above family members are deceased, please list their age at death and cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ENTRANCE RECORD**

**When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they both be seeking and working toward the same goals.**

**Chiropractic has one goal. It is therefore important that you understand the goal and our means to attain it. In this way there will be NO confusion, misunderstanding or disappointment.**

1. **YOU must realize that Chiropractic is NOT a substitute for medical treatment of any kind, in any way, for any reason. Also, NO statement of the Chiropractor is intended as a medical diagnosis and should not be confused as such. Patients usually want to get rid of whatever ailments. Symptoms or conditions are bothering them. This however, is NOT the goal of the chiropractor. Chiropractic is not intended to be treatment of the symptoms of a medical condition or to treat the cause or causes of a medical condition.**
2. **The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. Subluxations come from many causes and prevent various organs, glands, and tissues from functioning properly.**
3. **By means of a chiropractic adjustment, subluxations are corrected (reduced) and the normal nerve function restores itself. The goad of chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability to the body to work a maximum efficiency .**
4. **With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it. Nor does he offer advice regarding the treatment of disease is called, the chiropractor does not offer to heal or even treat it. Nor does he offer advice regarding the treatment of disease.**

**The information we receive from you is important. We ask only that which is necessary to our chiropractic health Maintenance Center. For this reason, please fill out this form completely and to the best of your ability. If you have any questions or there is any information you feel we should know, please mention it to the doctor.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the above, understand it fully, and undertake chiropractic care on this basis.**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**