Date:_____/______/_______

Patient's Full Name ____

Mailing Address:____ City:________________ State:_______ Zip:_____________

Cell Phone: _______-________-________ Additional Phone: _____-______-______ E-Mail: ______________________________

☐ Male ☐ Female Date of Birth:_____/____/______ ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:_______________________ Number of Children/ Ages____

Currently pregnant: ☐ Yes ____ weeks ☐ No # of vaginal births:____ # of Cesarean births: ____

How did you find us?		
☐ Existing Patient Name:______________ ☐ Physician Name:______________ ☐ Friend Name:______________	☐ BIRTHFIT ☐ Google ☐ Social Media	☐ Office Website ☐ MPI Website ☐ Other Website:___________
☐ Other____		

Social Security # ________ - ________ - ________

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed Occupation:___________________

Employer:______________________

Emergency Contact:______________________________ Relationship:______________________ Phone: _______-________-________

Family Physician: __________________________ City: _________________________ State:____________ Phone_________________

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: ____

Chiropractor's Name/Location ____ _____________________________ ________________

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

- You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.
- I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Patient Signature:_____________________________________ **Date:**______/_______/____________

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

Present complaint(s):____

When did your symptoms begin? (Specific date if possible)____

How did your symptoms begin? (i.e. Lifting, ect.)____

In the past have you had anything similar to this? ☐ Yes ☐ No Please explain____

If applicable, please select one of the following reasons for your visit:

☐ Pregnancy ☐ Diastasis Rectus Abdominis ☐ Pelvic Floor Dysfunction ☐ Wellness

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Is your Pain:	Was the Onset:	Pain is aggravated by:	Pain is improved by:
☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies	☐ Gradual ☐ Sudden	☐ Walking ☐ Sitting ☐ Riding in a car ☐ Standing ☐ Lifting ☐ Bending ☐ Stretching ☐ Twisting ☐ Other______________________	☐ Medication ☐ Rest ☐ Exercise ☐ Therapy ☐ Chiropractic Adjustment ☐ Ice ☐ Heat ☐ Other______________________________

☐ Yes ☐ No Is pain affecting your ability to work or be active? If Yes explain:____

☐ Yes ☐ No Any change in bowel/bladder function, including stress incontinence? If Yes explain:_________________________________

☐ Yes ☐ No Any fever or chills? If Yes explain:____

☐ Yes ☐ No Any dizziness associated with symptoms? If Yes explain:____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain:____________________________

☐ Yes ☐ No Are your complaints affecting your sleep? If Yes explain:____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain:____________________________________

☐ Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If Yes explain:____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? If Yes explain:____

☐ Yes ☐ No Have you had any prior treatment, including any physical therapy? If Yes, what treatment?_____________________________

☐ Yes ☐ No Have you been in the hospital or had surgery for any reason? If Yes explain:_____________________________________

☐ Yes ☐ No Have you ever been in an accident? If Yes explain:____

What **non-prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other_________________

How often?
☐Daily ☐Weekly ☐Other:__________

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Meds	☐ Birth Control Pill ☐ Cholesterol Meds ☐ Insulin ☐ Thyroid Meds	☐ Nerve Pills ☐ HRT ☐ Sleeping Aid ☐ Recent Antibiotics

☐ Other_____________________________________
☐ None
Specific names if possible:__________________________________

☐ Yes ☐ No Do you smoke? If Yes how much?:____

If you have quit smoking, when did you quit?____

☐ Yes ☐ No Do you consume alcohol more than socially?

☐ Yes ☐ No Do you exercise? If Yes what is your routine?____

Please circle regular dietary intake: fruits vegetables meats grains dairy products nuts/seeds/berries sugars

Paleo/Primal gluten-free

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

Mother:______________________________________

Father:____

Brother(s):____________________________________

Sister(s):_______________________________________

Other:____

Other:____

Other health concerns?

____