W E L C O M E

ABOUT YOU: Today's Date: _____

Name: _____

□ Male □ Female Date of Birth __/__/__ Age ____ Height _____ Weight ____ SS# _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated
Education: # of years completed: _____

Home Address: _____
Street Address/P.O. Box City State Zip Code

Email address: _____ How did you hear about us? _____
(Please be specific)

Home Phone #: _____ Cell Phone #: _____ Work Phone: _____

Employed: □ Fulltime □ Part Time □ Unemployed Job Description: _____

Employer Business Name: _____ Occupation: _____ Years Employed: _____

Employer's Address: _____
Street City State Zip Code

What type of injury are we seeing you for?
- □ Auto
- □ Other
- □ Work
- □ Sports Injury

EMERGENCY CONTACT INFORMATION:
Emergency Contact Person: _____
Phone #: _____ Relationship: _____

INSURANCE INFORMATION:
- □ I will be paying for the services myself
- □ Please bill: □ Auto Insurance □ Worker's Compensation □ Health Insurance □ Other _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group #: _____ Subscriber's SS#: _____

Subscriber's Name: _____ Relationship: _____ Subscriber's Date of Birth: __/__/__

Subscriber's Address: _____ Subscriber's Phone Number _____

Name of Attorney: _____ Telephone #: _____ Date Retained: _____

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from Premier Health & Longevity Center (PHLC) (DBA: Premier Chiropractic Medicine). The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. I understand that I have a responsibility to communicate honestly with PHLC and to notify them of any changes in my health status.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, Auto, private insurance and other health plans to PHLC. I also authorize PHLC to release any protected health information required to secure payment. Accounts over 90 days delinquent may be subject to a monthly finance charge of 1.5%, 18% annually.

Release of Records: I authorize PHLC to release all health records necessary for my treatment and/or evaluation.

Patient's Signature: _____ Date: __/__/__

Responsible Party's Signature (if patient is a minor): _____ Date: __/__/__

Do you currently or have you had: Please mark all that apply

	Current	Past
Sleep Problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Irritability	☐	☐
Mood Swings / changes	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Growing moles or lumps	☐	☐
Wear glasses or contacts	☐	☐
Glaucoma	☐	☐
Light bothers eyes	☐	☐
Other eye problems	☐	☐

Date of last eye exam: _____

Hearing difficulties	☐	☐
Ringing in ears	☐	☐
Sinus infection	☐	☐
Motion sickness	☐	☐
Dental Problems	☐	☐

Date of last dental exam: _____

Do you currently or have you had: Please mark all that apply.

	Current	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Leaking urine	☐	☐
Urinating at night	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Heartburn	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Loss of smell	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐
Varicose veins	☐	☐

Patient Name _____

Do you currently or have you had: Please mark all that apply

	Current	Past
Asthma	☐	☐
Eczema	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Liver trouble	☐	☐
Anemia	☐	☐
Bleeding or bruising tendency	☐	☐

Do you currently or have you have: Please mark all that apply:

	Current	Past
Low blood pressure	☐	☐
Racing, pounding heart	☐	☐
Ankle swelling	☐	☐
Lung or breathing problems	☐	☐
Pneumonia	☐	☐

Do you currently or have you had: Please mark all that apply:

	Current	Past
History of trauma	☐	☐
Infection	☐	☐
Unexplained weight loss	☐	☐
Unusual fatigue	☐	☐
Dizziness / Poor balance	☐	☐
Vomited blood	☐	☐
Bloody or black stools	☐	☐
Change in appetite	☐	☐
Fevers	☐	☐
Night Sweats	☐	☐
High blood pressure	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐
Loss of bowel or bladder control	☐	☐
Headaches	☐	☐
Muscle **weakness** or paralysis	☐	☐
Memory loss	☐	☐
Severe trauma	☐	☐
Direct head trauma	☐	☐
Lost consciousness	☐	☐
Poor coordination	☐	☐
Night pain	☐	☐
Difficulty Swallowing	☐	☐
Recent infection	☐	☐
History of osteoporosis	☐	☐
History of cancer	☐	☐
Difficulty breathing	☐	☐
Abdominal pain	☐	☐
Use of corticosteroids	☐	☐
Use of anticoagulants	☐	☐
Use of birth control pills	☐	☐
Numbness in groin (saddle anesthesia)	☐	☐
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	☐	☐
Pain fails to improve with rest	☐	☐
Pain greater than 4 weeks	☐	☐
Prolonged use of corticosteroids	☐	☐
Intravenous drug use	☐	☐

ABOUT YOUR FAMILYHISTORY:
Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Chronic Pain	Other	If deceased, cause of death
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brothers/Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENT or WORK INJURIES — AREAS INVOLVED INDICATE EVALUATIONS & TREATMENT
(Please be as specific as possible) — Year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Name: _____ Date: _____

TESTS: Please list the MOST recent date:

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

HABITS:	YES	NO	If yes, please describe:
Smoking	☐	☐	Packs per day: 0 – ½ ☐ ½ - 1 ☐ 2 or more ☐ Duration _____
Alcohol Consumption	☐	☐	# Drinks per day _____ Drinks per week _____
Coffee or Tea/Caffeine Drinks	☐	☐	Cups per day _____
Other Drug Use (Street Drugs)	☐	☐	_____
Exercise	☐	☐	Daily ☐ Weekly ☐ Monthly ☐ Type _____
High Stress Levels	☐	☐	Reason _____

HOBBIES OR INTEREST: _____

_____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, herbs

_____

_____

ALLERGIES: Please list all known allergies, especially to medicines. _____

_____

Treatment you are receiving or have received:

Medical care ☐ Chiropractic care ☐ Other ☐ _____

Name of General/Family Physician _____

Are you: Right handed ☐ Left handed ☐ Ambidextrous ☐

Do you currently or in the past have: Please mark all that apply

	Currently	Past
Back pain or stiffness	☐	☐
Neck pain or stiffness	☐	☐
Scoliosis/Kyphosis	☐	☐
Shoulder pain	☐	☐
Hip pain	☐	☐
Foot pain or trouble	☐	☐
Swollen or painful joints	☐	☐
Cold hands or feet	☐	☐
Numbness or pain in the arms, hands or fingers	☐	☐
Numbness or pain in the legs, feet or toes	☐	☐

MALES ONLY

Do you have:

☐ Changes in urine stream ☐ Prostate trouble

☐ Lumps in testicles ☐ Sex concerns

Date of last prostate exam: _____

FEMALES ONLY

Do you have:

☐ Menstrual problems ☐ Vaginal discharge

☐ Abnormal bleeding ☐ Tubal infections

☐ Breast lumps or pain ☐ Sex concerns

☐ Problems getting pregnant

Age periods began: _____

Number of pregnancies: _____

Number of miscarriages or abortions: _____

Number of Cesarean Sections: _____

Type of birth control: _____

Date of last gynecological exam: _____

Date last period began: _____

Are you currently or possibly pregnant? _____

Please list any other health related condition not covered in this form:

_____

DOCTOR'S NOTES: _____

_____

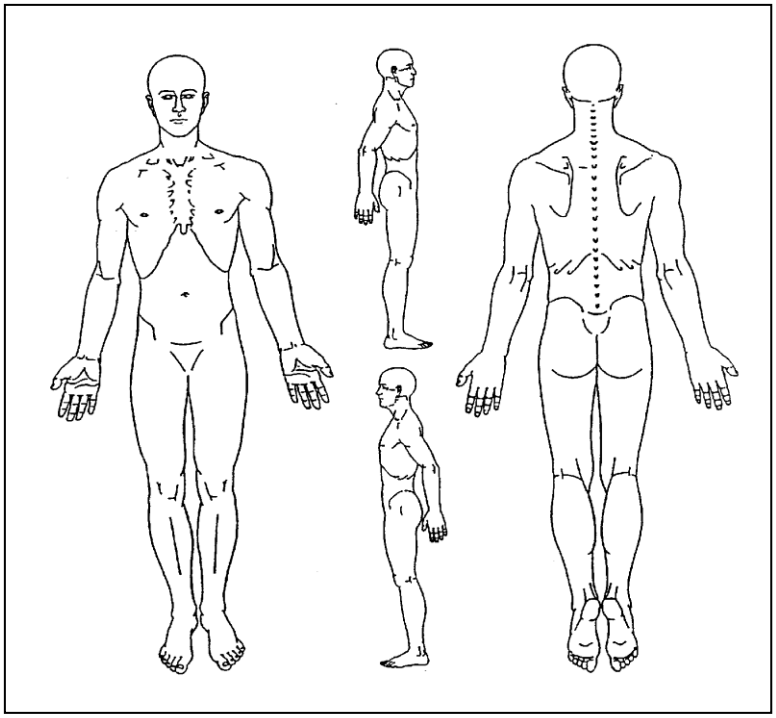
_____

Patient Name: _____ **Date:** _____

PAIN LOCATION, INTENSITY & FREQUENCY QUESTIONNAIRE

PATIENT NAME _____ **DATE** _____

Use letters on diagram below to indicate type and location of discomfort		
A = **ACHE**	**B =** **BURNING**	**C =** **STABBING**
N = **NUMBING**	**P =** **PINS & NEEDLES**	**O =** **OTHER**



Primary Complaint: _____
Describe the character of the complaint: ___Sharp/Stabbing ___Sharp/Dull ___Aches ___Dull ___Soreness ___Weakness ___Throbbing ___Numbness ___Shooting ___Gripping/Constricting ___Burning ___Tingling
How often is complaint present? ___Consistent (76-100%) ___Frequent (51-75%) ___Occasional (26-50%) ___Intermittent (<26%)
Does your complaint radiate? Yes No If yes, where?_____
Rate the intensity of your complaint (circle one): none 0 1 2 3 4 5 6 7 8 9 10 unbearable
When did your complaint begin? _____ **Is it**: __better __same __worse
Describe how your complaint began:_____
(If auto accident describe in detail) _____
What makes your complaint better? _____
Does it interfere with your: ___Work ___Sleep ___Daily Routine ___Recreation
Activities that are painful: ___Sitting ___Standing ___Walking ___Bending ___Lying Down
Doctors consulted for this complaint: _____

Secondary Complaint: _____
Describe the character of the complaint: ___Sharp/Stabbing ___Sharp/Dull ___Aches ___Dull ___Soreness ___Weakness ___Throbbing ___Numbness ___Shooting ___Gripping/Constricting ___Burning ___Tingling
How often is complaint present? ___Consistent (76-100%) ___Frequent (51-75%) ___Occasional (26-50%) ___Intermittent (<26%)
Does your complaint radiate? Yes No If yes, where?_____
Rate the intensity of your complaint (circle one): none 0 1 2 3 4 5 6 7 8 9 10 unbearable
When did your complaint begin? _____ **Is it**: __better __same __worse
Describe how your complaint began:_____
(If auto accident describe in detail) _____
What makes your complaint better? _____
Does it interfere with your: ___Work ___Sleep ___Daily Routine ___Recreation
Activities that are painful: ___Sitting ___Standing ___Walking ___Bending ___Lying Down
Doctors consulted for this complaint: _____