

WELCOME TO STONE FAMILY CHIROPRACTIC CENTER

The purpose of this office is to educate as many families as possible about the spinal condition known as Vertebral Subluxations. Vertebral Subluxation damages an optimally functioning spine and your ability to have optimal health. Your experience with this office will not only be of healing but also of learning the truth about **Optimal Health and Healing**.

PATIENT INFORMATION

Print Full Name: _____ Name you go by: _____ Today's Date: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Date of Birth: _____ Social Security #: _____ E-mail address: _____
Height: _____ Weight: _____ Please Check (✓): Married Single Other # of children: _____ ages: _____
Employer: _____ Street Address: _____ City: _____
State: _____ Zip: _____ Driver's License #: _____ State: _____
Where did you hear about our office or who referred you? _____

PHONE NUMBERS

Home: _____ Work: _____ ext. _____ Cell: _____
Preferred phone number: Home / Work / Cell Best time to reach you: _____
In case of emergency, notify: _____ Relationship: _____ Phone: _____

INSURANCE

Do you have medical insurance? Yes No Insurance Company Name: _____
Insured's Name (if different from patient): _____ Relationship to patient: _____
Insured's Date of Birth: _____ Insured's Social Security Number: _____
Insured's Employer: _____ Insured's employer address: _____

HEALTH HISTORY

Please write down the reason you are seeking chiropractic care: _____
Is this due to an accident or injury? Yes No Date: _____ Type of accident: Auto Home Other _____
Is your condition getting worse? Yes No Does it interfere with your: Work Sleep Daily routine Exercise
▪ Subluxations can put pressure on nerves for long periods of time. How long have you had the above complaint(s): _____
▪ Nerve pressure & irritation can be constant or occasional. How often do you have the above complaint(s): _____
▪ Irritation to different nerve fibers can create different sensations. Is yours sharp, dull, throbbing, burning, numb, and/or achy: _____
▪ Subluxations can cause weakening of the entire spine. Is yours worse in the morning, evening, and/or after a specific activity? _____
Are you under the care of any other doctor for this problem? Yes No Name of Doctor: _____
Medications you now take: Tylenol Advil / Ibuprofen High Blood Pressure Painkillers Muscle Relaxers
Allergy Anti-Depressants Cold Medications Hormone Replacement Others (please specify) _____
Exercise: None 1-3x week 4-7x week Are you a member of a health club or gym: Yes No
What nutritional supplements do you take? _____
Do you smoke? Yes No If yes, how long? _____ Do you sleep on your stomach? Yes No Sometimes
Please list any past surgeries and dates: _____

FEMALES ONLY

Is it possible that you are pregnant? Yes No If yes, due date: _____ Are you on Birth Control Pills? Yes No

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobby related) that could cause Vertebral Subluxations. Help us discover a few of yours.

- How many total accidents or minor fender benders have you been in? 5+ 3-4 1-2 None
- Which of the following sports have you been involved in? Football Basketball Soccer Running Gymnastics/Cheerleading Martial Arts Horseback riding Other: _____
- Have you ever Fallen down the stairs Slipped/Fell on the ground (or ice) Had a sports injury Had a stress or strain while working Broken a bone if so, which one? _____
- Do you ... Sit more than 4 hours per day Drive more than 2 hours per day Perform repetitive tasks (typing/lifting)

WORK & FAMILY HISTORY

Your Occupation: _____ Work Duties: _____
 Spouse's health status: _____ Children's health status: _____
 Past or present health problems of parents & siblings: _____

CHIROPRACTIC HISTORY

When did you last see a Chiropractor? _____ Reason for care: _____
 What spinal maintenance programs were you given to maximize the future stability of your spine? _____
 Did you follow it: Yes No If not, why? _____
 Are other family members under chiropractic care? Yes No Who? _____

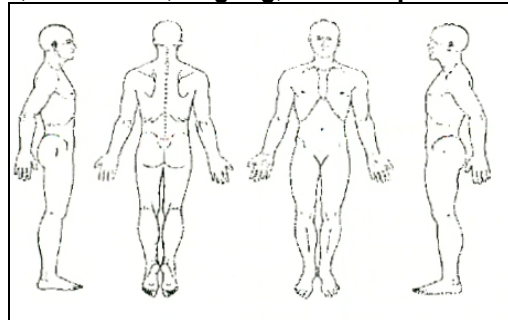
WELLNESS COMMITMENT

At Stone Family Chiropractic Center, we are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check (✓) all that apply that are closest to your personal health goal(s):
 Symptom Relief/Temporary Relief Restore Health Maximum Correction Wellness & Prevention Improved Performance

Subluxations can cause malfunction in any part of the body. Please check any health issues you are currently experiencing or have had in the past:

| Condition or Symptom | Constantly or Frequently | Sometimes or Occasionally |
|-----------------------------|--------------------------|---------------------------|
| Headaches / Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia | <input type="checkbox"/> | <input type="checkbox"/> |
| Earaches /Hearing problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder/Arm/Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness/Tingling in arms | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Colds | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/Difficulty Breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies / Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness/Tingling in legs | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Back Pain / | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis / Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Female / Male Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Place an "X" on the diagram below where you have any pain, numbness, tingling, or other problems.



I do hereby authorize Stone Family Chiropractic Center to administer such care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and 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 non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

 Patient's signature (or parent/guardian) Date