Elev8 Chiropractic

Your Next Level Awaits!

ABOUT YOU

Last Name _____ First Name _____ Middle Name or Initial _____

Gender
○ Male ○ Female

Birthdate _____ Age _____ Social Security Number _____

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ E-mail: _____

How did you hear about Elev8? _____ Employer's Name/Company _____

What is your Occupation? _____

Status:

○ Minor ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Do you have children?

○ Yes ○ No

How many Children? _____

INSURANCE INFORMATION

Primary Health Insurance Co. Name _____ Insured's ID# _____ Customer Service # (On back of card) _____

Secondary Insurance _____ Insured's ID# _____ Customer Service # (On back of card) _____

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered and the staff has permission to release any informaion required to process insurance claims. I acknowledge any insurance I have is a contract between the carrier and myself and I am responsible for the payment of any covered or non-covered services I receive.

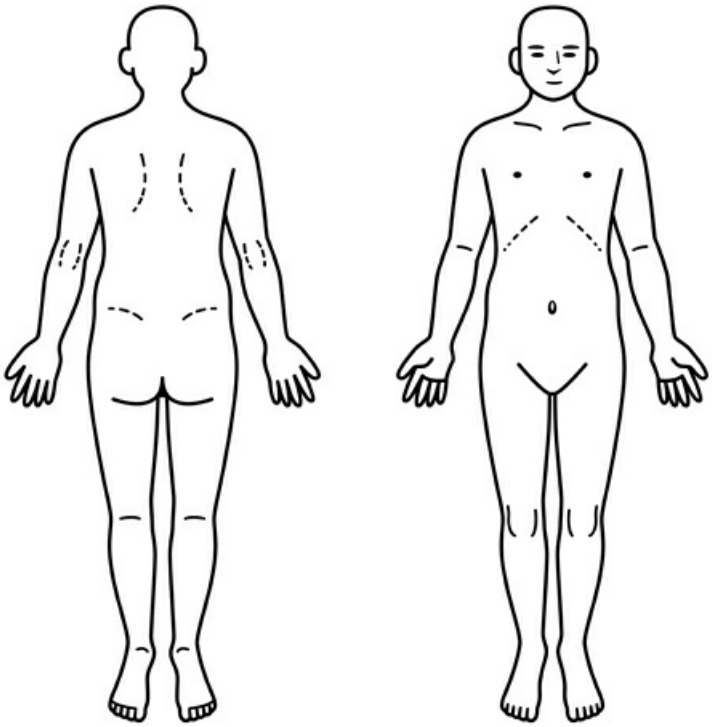
Please click to acknowledge you agree with the above statement.

○ Agree ○ I do not Agree

Your Current Concern(s)

HOW CAN WE HELP YOU?

Please mark on the diagram any areas where you are experiencing issues.



When did this start?

How did it start?

How would you describe the pain/discomfort? Check all that apply.

☐ Dull ☐ Sharp ☐ Throbbing ☐ Aching ☐ Tingling/Numbness ☐ Stabbing ☐ Cramping ☐ Stiffness ☐ Other

Does the pain travel to any other areas? If so, where?

☐ Pain does not travel ☐ Left shoulder/upper arm ☐ Right shoulder/upper arm ☐ Left arm to hand
☐ Right arm to hand ☐ Left buttock ☐ Right buttock ☐ Left upper leg ☐ Right upper leg ☐ Left leg to foot
☐ Right leg to foot ☐ Other

Is the pain constant or does it change during the day?

☐ Constant ☐ Worse in the morning ☐ Worse at midday ☐ Worse at the end of the day ☐ Worse at night
☐ Comes and goes intermittently

Have you noticed anything that makes the pain worse? Check all that apply.

☐ Nothing ☐ Sitting ☐ Standing ☐ Walking ☐ Bending/Stooping ☐ Lifting ☐ Sleeping ☐ Sneezing/Coughing
☐ Straining ☐ Reaching ☐ Twisting/Turning ☐ Looking Up/Down ☐ Moving ☐ Lying on Back ☐ Lying on Side
☐ Lying on Stomach ☐ Driving ☐ Exercise ☐ Stretching ☐ Other

Have you noticed anything that makes the pain better?

☐ Nothing ☐ Sitting ☐ Standing ☐ Lying on Back ☐ Lying on Side ☐ Lying on Stomach ☐ Support/Bracing
☐ Movement ☐ Resting ☐ Heat ☐ Ice ☐ Topical Pain Cream/Gel ☐ Over-the-Counter Medication
☐ Prescription Medication ☐ Stretching ☐ Exercise ☐ Massage ☐ Other

Please describe how this issue is affecting your day-to-day life.

What other providers have you seen regarding this issue, if any?

☐ None ☐ General Practitioner/Family Doctor ☐ Orthopedist ☐ Neurologist ☐ Other Medical Specialist
☐ Physical Therapist ☐ Massage Therapist ☐ Acupuncturist ☐ Another Chiropractor ☐ Other

Describe what has happened with these other providers. (Testing/Imaging. Treatments. Prescriptions. Recommendations. Diagnoses/Opinions.)

Has this or something similar happened in the past?

○ Yes ○ No

If yes, how have you managed this previously?

Have you ever been treated by a Chiropractor?

○ Yes ○ No

If yes, how long has it been since your last adjustment?

Is there anything else you think we should know about this problem?

Do you have any other health and vitality concerns/issues that you would like us to address?

6. YOUR HEALTH AND WELL-BEING

What other health conditions/diagnoses do you currently have? (Please include anything you are in treatment for, are taking medication for, or is currently being managed by another health care provider.)

Please list any medications you are currently taking. (Please include over-the-counter medicines)

Do you take Supplements or Vitamins?

Please list the vitamins/supplements you are taking.

○ Yes ○ No

Do you exercise?

○ Yes ○ No

What type of exercise do you do?

Hours per week?

Rate the quality of your diet?

○ Good ○ Fair ○ Poor

Rate the quality of your sleep

○ Good ○ Fair ○ Poor

How many hours of sleep per night are you getting?

Rate your stress level.

○ Low ○ Moderate ○ High

Do you consume alcohol?

How many drinks per week?

How many caffeinated beverages daily?

How many carbonated beverages daily?

Do/Did you smoke?

○ Yes ○ No

How much do you smoke?

When did you quit?

Do you take recreational drugs?

○ Yes ○ No

Please list any serious/major health conditions or issues you have had in the past?

Please list any surgeries you have had.

Please list any serious accidents you have had in the past.

What, if any, allergies do you have?

What else should we know about your family's health history?

With my signature, I guarantee this form was completed correctly to the best of my knowledge and unstand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that by typing my signautre below, this constitutes my digital signature.

Print your full name and sign:

X

Ip Address