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MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIONIZE HEALTHCARE IN OUR COMMUNITY.

Welcome to Chiropractic!

This questionnaire is for the purpose of getting to you know you better in order to provide the best possible chiropractic services. Please complete this form as honestly and completely as possible.

Today's Date:__________________

Name:____ Date of Birth:____________________ Age:__________

Any change in your personal information (i.e., address, phone number, marital status, etc.) from what we have?

☐ Yes, there is a change *(please provide this information)* ☐No Change

Who can we thank for referring you to chiropractic care?____

Why are you seeking care with us? ☐Pain ☐Wellness ☐Nutrition/Lifestyle

In your own words, what area(s) of your health are you concerned about?:

____
____
____
____
____

How long has this been going on? ____

Have you missed work due to this condition: ☐Yes ☐No

Is this due to an Auto Accident/Worker's Compensation case? ☐Yes ☐No **If yes, please see receptionist.*

Have you had any previous tests, x-rays, CT scans, or MRI's previously taken? ☐Yes ☐No

What was done?____ Where?______________________________

Have you been to a chiropractor before? ☐Yes ☐No

HIPAA Disclosure

In an effort to maintain patient confidentiality and the guidelines within the HIPAA regulations, please fill out this section in regards to having someone other than you obtain information regarding upcoming appointments and/or information from your *chiropractic* records, specifically.

☐ I decline to give permission to a family member/friend.

☐ I give permission to the following family/friend:

Name: ________________________________ Relation: ______________________ Ph #:____________________

Patient Signature:____ Date:____________________________________

Adult (Chiro)