N8 UPPER CERVICAL CHIROPRACTIC

THIS INFORMATION IS NECESSARY FOR OUR FILES & WILL BE CONSIDERED CONFIDENTIAL

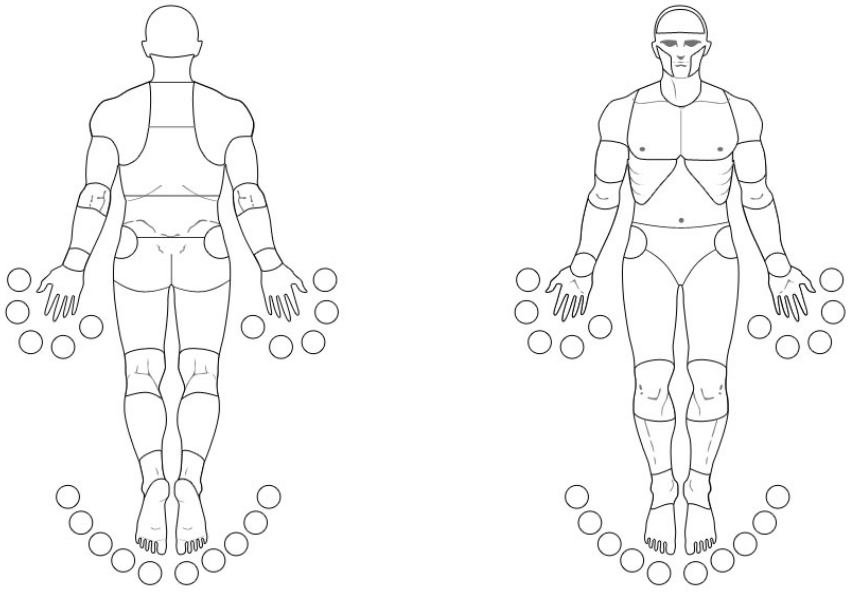
WELCOME…Thank You for choosing our practice for your spinal correction needs! Please complete this form in ink. If you have any questions or need assistance, do not hesitate to ask for assistance. We will be happy to help. (PLEASE PRINT)

NAME _____ DATE _____

FAMILY HISTORY OF ILLNESS:					
☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Ulcer	☐ STD'S	☐ Spinal Disc Disease
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Polio	☐ Sinus trouble	☐ Low Blood Pressure
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Scoliosis	☐ Epilepsy	☐ Mental/ Emotional
☐ Arthritis	☐ Diabetes	☐ Diverticulitis	☐ Prostate trouble	☐ Thyroid trouble	☐ High blood pressure
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	
TYPE OF CANCER	☐ Breast	☐ Lung	☐ Other:		
Other Illness:					

PLEASE INDICATE your reason(s) for this visit below: Please indicate any major areas of concern by using the key and marking the body regions on the image below. Please provide additional details of your primary concern on the next page.

P	Sharp Pain
D	Dull / Achy
S	Shooting
N	Numbness
T	Tingling
B	Burning
R	Throbbing
M	Spasm
W	Weakness



-Please proceed to opposite side-

PLEASE USE the following key to answer the following section: Please describe the MAJOR CONCERN you are experiencing. Further indicate the location of the pain by circling F, B, R or L for Front, Back, Right or Left.

Main Area of Concern		(Please indicate your Primary Condition only)_____
Frequency		□ Infrequent <25% □ Occasional 25% - 50% □ Frequent 50% - 75% □ Constant 75% — Location: □ Left □ Center □ Right □ Both
Timing		Worst during □ morning □ afternoon □ evening □ during night □ light / moderate activity
Pain Level Rating 0 = NONE; 10 = WORST		□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
What makes it better?		□ Lying Down □ Medication □ Nothing □ Moving □ Sitting □ Standing □ Stretching □ Chiro. Treatment □ Heat Ice □ Rest □ Lean(L / R) □ Lying on(L / R)
What makes it worse?		□ Bending □ Lights □ Noise □ Chewing □ Breathing □ Housework □ Lying Down □ Lifting □ Working □ Sitting □Standing □ Walking □ Coughing □ Sneezing □ Reaching □ Bending(L / R) □ Turning(L / R) □ Bowel Movement □ Touching Area □ Weight Bearing □ Climbing (UP / DOWN) Stairs □ Other _____
Does the pain radiate to any other locations	Upper Body	□ Jaw (L / R) □ Eye (L / R) □ Ear (L / R) □ Head (F / B / L / R) □ Arm (L / R) □ Hand (L / R) □ Shoulder (L / R) □ Fingers (L / R)
	Mid Body	□ Ribs (L / R) □ Chest (L / R) □ Abdomen (L / R) □ Groin (L / R) □ Buttock (L / R) □ Hip (F / B / L / R)
	Lower Body	□ Knee (L / R) □ Shin (L / R) □ Thigh (F / B / L / R) □ Calf (L / R) □ Foot (L / R) □ Toes (L / R)
Associated with		□ Dizziness □ Nausea □ Visual Problems □ Ringing / Buzzing in ears □ Inflammation □ Numbness □ Tingling □ Decreased Motion □ Allergies / Sinus □ Light Sensitive □ Sound Sensitivity □ Loss of balance
Additional Comments		

If you have additional major areas of concern, please request an additional form from the front desk.

Agreements

I understand that I am financially responsible for all charges &/or interest accrued due to unpaid balances as per N8 Upper Cervical Chiropractics' policies.

N8 Upper Cervical Chiropractic does not deny any benefits or service because of race, color, national origin, age, gender, and disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Manager of this facility. You will not suffer any penalty because you file a complaint.

Patients are encouraged to leave valuables at home or with a family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

My signature on this document confirms that I have read, understand and agree to comply with all policies, consents, terms & conditions regarding my responsibilities to this Facility and that I grant the staff, therapists & doctors of this Facility to use and share my confidential health information with others in order to treat me &/or in order to arrange for payment of my bill &/or for issues that concern this Facilities operations and responsibilities. I will direct all questions concerning this or other documents and policies to the staff of N8 Upper Cervical Chiropractic which encourages questions to avoid misunderstandings.

Guarantor Signature _____Date _____
(Or legal guardian if minor)