

CHIRO4SPORTS

Jeffrey Ho DC, Windward Chiropractic & Wellness Inc. D/B/A CHIRO4SPORTS

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W

Social Security #: _____ Occupation: _____

Employer: _____

Spouse's Name: _____ Age: _____ Occupation: _____

How many Children do you have? _____

Have they or any other members of your family received Chiropractic Care? _____

Do you have health insurance? Y N

Name of Company: _____ Policy #: _____

List any surgeries or hospitalizations: _____

List medications (prescription & over the counter) that you are currently taking or have taken in the last 6 months: _____

Daily intake: Coffee _____ Tea _____ Alcohol _____ Tobacco _____

Have you had chiropractic care in the past? Y N If yes, Dr. _____

Date of last chiropractic visit: _____ Date of last chiropractic X-rays: _____

Please mark (C) for current or (P) for past conditions for the following:

- | | | |
|----------------------------|------------------------|---------------------------|
| _____ Fractured bones | _____ Headaches | _____ Heart Problems |
| _____ Auto accidents | _____ Neck pain | _____ Stroke |
| _____ 0-1 yr. Ago | _____ Low back pain | _____ High Blood Pressure |
| _____ 1-5 yrs. Ago | _____ Mid back pain | _____ Lung Problems |
| _____ more than 5 yrs. Ago | _____ Shoulder pain | _____ Cancer |
| _____ Knocked unconscious | _____ Pain in arms | _____ Diabetes |
| _____ Slip/Fall | _____ Hip pain | _____ Constipation |
| _____ Sporting Injury | _____ Pain in legs | _____ Digestive Problems |
| _____ Work accident | _____ Numbness in arms | _____ Allergies |

INSURANCE NOTICE:

As a courtesy to you, this office will submit claims to your insurance company and prepare any necessary reports and forms to assist you in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to your account. Some of the care and services you receive may not be covered by insurance. If we have knowledge that a service or product is not covered by your insurance, we will do our best to notify you in advance. However, your insurance policy is a contract between YOU and the INSURANCE COMPANY. You are ultimately responsible for payment in full if the carrier determines that a service or product is not covered by your policy.

I, _____, attest that I have read and fully understand the above statements.

Signature

Date

CONSENT FOR MINOR:

I do hereby consent for examination and chiropractic care for _____,
for whom I am the parent/ legal guardian.

Guardian's Signature

Date

X-RAY CONSENT

The purpose of the x-ray examination is to analyze the spine for vertebral subluxation, rate, and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed and I must determine if I should seek further advice from an additional healthcare provider. I understand that this should not interfere with the subluxation correction care provided by this office. I fully understand the above and consent to chiropractic spinal x-rays.

Patient Signature _____ Date: _____

Pregnancy Release

This is to certify to the best of my ability I am not pregnant and Chiro4Sports has my permission to perform an x-ray evaluation. I understand the risks of taking an x-ray to an unborn child.

Date of last menstrual period: _____

Patient Signature: _____

Date: _____

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____

2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

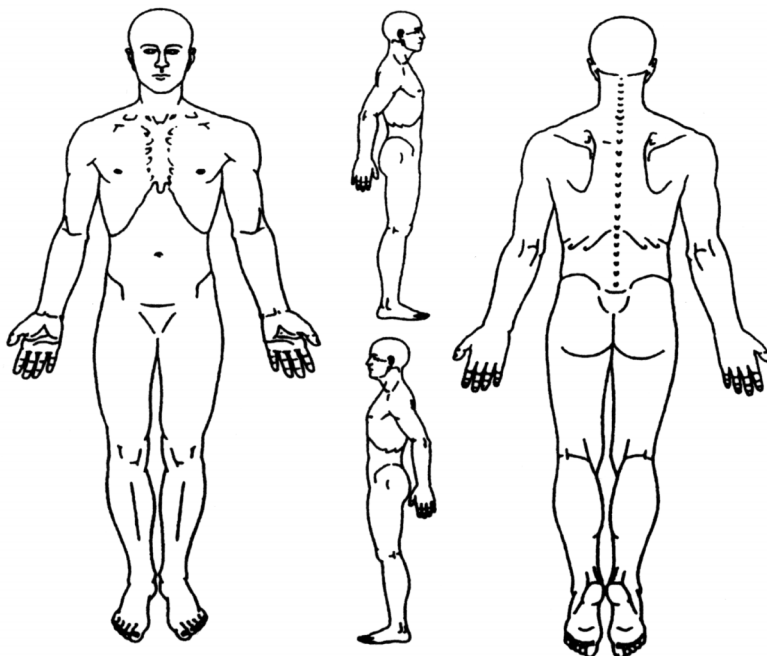
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			Intermittent			Frequent			Constant		
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint**? _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

- personal care _____
- lifting _____
- reading _____
- concentrating _____
- work _____
- driving _____
- sleeping _____
- recreation _____
- walking _____
- sitting _____
- standing _____
- social life _____

6. When do you notice it most? AM PM

How long does it last? _____ Mins _____ Hrs

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? Yes No

10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider never received care for this problem.

11. Have you lost time from work because of it? Yes No
Dates? _____ to _____

12. Are you Pregnant? Yes No

13. What was the first day of your last menstrual cycle? _____

14. Number of pregnancies? _____ Miscarriages? _____

Signature: _____

Date: ___ / ___ / ___