

Welcome to Mountain Park Chiropractic

Personal Information

Full Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Gender M ☐ F ☐
Date of Birth: ____/____/____ Age: _____ Social Security Number: _____ - ____ - ____
Height: _____ Weight: _____ Occupation: _____ Employer: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Marital Status: _____ Spouse Name: _____ Work Phone: _____
Spouse's Employer: _____ Spouse's Date of Birth: _____
Spouse's Social Security Number: _____ - ____ - ____ How did you hear about our office? _____
E-MAIL _____

Insurance & Emergency Information

Insurance Company's Name: _____ Phone Number: (____) _____
Name of Insured: _____ Patient's relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Social Security Number of Insured: _____ Date of Birth of Insured: _____
Friend/Relative not living with you: _____ Phone Number: _____

Health & History Information

1. Please check your PRESENT symptom(s):
- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blurred or Double Vision |
| <input type="checkbox"/> Neck Pain / Stiffness | <input type="checkbox"/> Buzzing or Ringing in Ears |
| <input type="checkbox"/> Extreme Neck Stiffness with pain or electric shocks in arms | <input type="checkbox"/> Loss of Taste / Smell |
| <input type="checkbox"/> or legs when moving neck | <input type="checkbox"/> Memory Loss / Confusion |
| <input type="checkbox"/> Neck Pain with difficulty swallowing | <input type="checkbox"/> Sinus Trouble / Asthma / Allergies |
| <input type="checkbox"/> Shoulder Pain / Stiffness (Right / Left) | <input type="checkbox"/> Dizziness / Fainting / Loss of balance |
| <input type="checkbox"/> Arm Pain / Tingling/ Numbness (Right / Left) | <input type="checkbox"/> Depression / Crying Spells |
| <input type="checkbox"/> Elbow Pain / Stiffness (Right / Left) | <input type="checkbox"/> Tension / Irritability |
| <input type="checkbox"/> Wrist Pain/ Stiffness (Right / Left) | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hand Pain/ Tingling/ Numbness (Right / Left) | <input type="checkbox"/> Nausea/ Vomiting /Stomach Problems |
| <input type="checkbox"/> Mid Back Pain / Stiffness | <input type="checkbox"/> Severe Pain (interrupts sleep) |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Low Back Pain / Stiffness | Normal Sleeping Hours _____ |
| <input type="checkbox"/> Low Back Pain with urinary problems | <input type="checkbox"/> Bowel / Bladder Problem |
| <input type="checkbox"/> Hip Pain / Stiffness (Right / Left) | <input type="checkbox"/> Constant pain that doesn't improve |
| <input type="checkbox"/> Leg Pain / Tingling / Numbness (Right / Left) | by changing position or lying down |
| <input type="checkbox"/> Leg Pain that worsens with exercise, but is relieved by resting | <input type="checkbox"/> Recent or current fever over 102 degree |
| <input type="checkbox"/> Loss of feeling in inner thighs | <input type="checkbox"/> Recent unexplained weight loss |
| <input type="checkbox"/> Knee Pain / Stiffness (Right / Left) | <input type="checkbox"/> Blood Pressure Problems (High / Low)) |
| <input type="checkbox"/> Muscle Jerking / Spasms / Soreness / Weakness / Shaking | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Jaw / TMJ | _____ |
2. Of the above, which is (are) your MAIN concern(s): _____
3. When did you first notice this (these) symptom(s)? _____
4. Please indicate and describe how the above condition(s) occurred:
- ☐ Injury ☐ auto accident ☐ on the job ☐ illness ☐ other
- Describe: _____

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5. Have you been treated for this (these) condition(s)? ☐ Yes ☐ No
If yes, when: _____ By whom: _____
For how long: _____ Results: _____
6. What percentage of your time do you feel pain or symptoms for the above condition(s)?
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
7. During what part of the day do you feel the worse? _____
8. Please indicate if the following have any influence over your condition(s)?
Moist Heat: ☐ Better ☐ Worse Ice: ☐ Better ☐ Worse OTHER: _____
Rest: ☐ Better ☐ Worse Activity: ☐ Better ☐ Worse _____
9. Are you currently under the care of a medical doctor or other type of health care professional for any condition?
☐ Yes ☐ No If yes, for what reason: _____
Name of doctor / provider: _____ Phone number: _____
10. Are you currently taking any over-the-counter/ prescription medication? ☐ Yes ☐ No
If yes, what: _____ Why: _____
Any home remedies supplement? _____ Why? _____
11. Have you ever had a stay in a hospital or a surgical procedure of any kind? If so, please complete the following:
Event: _____
Event: _____
Event: _____
12. Do you smoke? ☐ Yes ☐ No If yes, how much do you smoke in a day? _____
13. Do you exercise? ☐ Yes ☐ No If yes, describe activity? _____
How many times per week? _____ How long per session? _____
14. Evaluate your stress level: ☐ Severe/ Constant ☐ Moderate ☐ Minimal ☐ None

We invite you to discuss frankly with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and the patient.

Our office policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made with our office.

Signing below authorizes any payment of insurance benefits to be made directly to the doctor for services rendered in our office. It also authorizes Mountain Park Chiropractic to release any information required to process the insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

I also understand it is my responsibility to inform this office of any changes in my medical status.

I agree to allow this office to examine me for further evaluation.

Signature _____ Date _____