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):

- ☐ Headaches
- ☐ Neck Pain / Stiffness
- ☐ Extreme Neck Stiffness with pain or electric shocks in arms or legs when moving neck
- ☐ Neck Pain with difficulty swallowing
- ☐ Shoulder Pain / Stiffness (Right / Left)
- ☐ Arm Pain / Tingling/ Numbness (Right / Left)
- ☐ Elbow Pain / Stiffness (Right / Left)
- ☐ Wrist Pain/ Stiffness (Right / Left)
- ☐ Hand Pain/ Tingling/ Numbness (Right / Left)
- ☐ Mid Back Pain / Stiffness
- ☐ Chest Pain
- ☐ Low Back Pain / Stiffness
- ☐ Low Back Pain with urinary problems
- ☐ Hip Pain / Stiffness (Right / Left)
- ☐ Leg Pain / Tingling / Numbness (Right / Left)
- ☐ Leg Pain that worsens with exercise, but is relieved by resting
- ☐ Loss of feeling in inner thighs
- ☐ Knee Pain / Stiffness (Right / Left)
- ☐ Muscle Jerking / Spasms / Soreness / Weakness / Shaking
- ☐ Jaw / TMJ
- ☐ Blurred or Double Vision
- ☐ Buzzing or Ringing in Ears
- ☐ Loss of Taste / Smell
- ☐ Memory Loss / Confusion
- ☐ Sinus Trouble / Asthma / Allergies
- ☐ Dizziness / Fainting / Loss of balance
- ☐ Depression / Crying Spells
- ☐ Tension / Irritability
- ☐ Difficulty Breathing
- ☐ Nausea/ Vomiting /Stomach Problems
- ☐ Severe Pain (interrupts sleep)
- ☐ Difficulty Sleeping
  Normal Sleeping Hours _____
- ☐ Bowel / Bladder Problem
- ☐ Constant pain that doesn't improve by changing position or lying down
- ☐ Recent or current fever over 102 degree
- ☐ Recent unexplained weight loss
- ☐ Blood Pressure Problems (High / Low))
- ☐ Other (describe) _____

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** _____