# Agape Chiropractic

So we can better serve you, please fill in ALL requested information

**Date:**_____

**Last Name**_____**First Name**_____ **MI**_____ **M/F**

**Date of Birth** _____ **Social Security #**_____

**Marital Status Married/Divorced/Widow/Single Spouse Name:** _____

**Address** _____ **City** _____ **State** _____

**Email:** _____**Driver's License #**_____

**TEL: Cell** _____**Home** _____ **Work** _____

**What is the best way to contact you? Cell Phone Home Phone Work Phone Email**

**Occupation** _____ **Employer:**_____

**Emergency Contact:** _____

**How did you hear about us?** _____

**Have you ever been to a chiropractor for this or any other condition?? Yes/No**

**What condition prompted you to call/visit our office today?**_____

_____

**Who is your primary care physician/family doctor including address and phone?**

_____

**Do you have health insurance? Y or N**

**Insurance Carrier Name:** _____ **Verification Phone Number:**_____

**Insurance Carrier Address:**_____ **City**_____ **State** ___ **Zip**_____

**If this insurance is held by another person, such as a spouse, what is their name?** _____

**Insured's address:**_____ **Insured Date of Birth** _____

**Patient ID#** _____**Group #**_____

**Second Coverage details:**_____

_____

**we will contact your health insurance company to verify eligibility. We will determine the following: Available benefits, deductible, co-payment amount or percentage, specific payable codes, eligibility for treatment, evaluation, imaging, orthotics, physiotherapy and any necessary pre-authorizations or referrals.**

**Please check any that apply**

**___ Neck Pain ___ Mid Back Pain ____ Low Back Pain ____ Pain when sneezing/coughing**
**___ Neck Stiffness ___ Shoulder Pain Radiating Pain into buttock ___ Bowel/Bladder**
**___ Headaches ___ Arm pain/radiating ___Radiating Pain into legs ___Hip Pain**
**___ Sinus Issues ___Hand/Arm tingling ___Radiating in Both legs ___Knee/Leg Pain**
**___ Allergies ___ Pain in Traps ___ Muscle Weakness ___ Ankle/Foot Pain**

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**CURRENT SYMPTOMS - PLEASE FILL IN THE INFORMATION AS THOROUGHLY AS POSSIBLE- LEAVE NO BLANKS**

**What is chief complaint/location of PAIN:_____**

**How long have you had this symptom/pain? _____ Have you had this problem before? Y/N**

**If yes, how was it treated and what were the results? _____**

**DESCRIBE the pain (circle all that apply) dull sharp aching cutting throbbing burning numbing/numbness tingling cramping spasm stinging shooting pounding constricting other: _____**

**Pain FREQUENCY awake time: _____**

**Pain Intensity Choose/ circle one of the following:**

1. **The pain is annoying but does not interfere w/ activities &/or sleep though no narcotic medication is necessary.**
2. **The pain is tolerated buy interferes w/activities &/or sleep -some meds including narcotic meds may be necessary**
3. **Moderate pain-severely limits activities (recreation & socialization are severely limited) a&/or prevents sleep. The use of narcotic meds may be necessary.**
4. **The pain is marked and prevents activities and/or sleep with narcotic meds required which may not completely control the pain.**

**Does the pain RADIATE into the head, neck, shoulder, arm, hand, hip, leg, foot or other:_____**

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**If so, please indicate Right or Left side where applicable:**

**_____**

**In the AM _____ Twisting left _____ Straining_____ Sitting _____**
**In the PM _____ Twisting right_____ Standing_____ Lifting_____**
**Bending forward _____ Bending left _____ Coughing_____ Walking_____**
**Bending backward_____ Bending right_____ Sneezing_____ Running_____**

**What is the SEVERITY of pain on a scale of 1(mild) to 10 (severe) 1 2 3 4 5 6 7 8 9 10**

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**Where any of the above symptoms brought on by or aggravated by a motor vehicle accident, work related accident or other incident we should be aware of? If yes, explain _____**

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**If you were involved in a motor vehicle accident in the last two years, please complete the MVA form.**

**In reference to prior symptoms:**

**_____ I have NOT had prior symptoms similar to my current complaints**

**_____ My current complaints did exist before but were dormant**

**_____ My current complaints already existed but were worsened/aggravated**

**Has your history contributed to your symptoms:**

**_____ My history HAS contributed to my symptoms**

**_____ My history HAS NOT contributed to my symptoms**

**_____ I am NOT SURE if my history has contributed to my symptoms**

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**Family History- Does you or your immediate Family suffer from any of the following**

**Is there any relevant family history we should be aware of including incidences of the following:**

| | | | |
|---|---|---|---|
| **ARTHRITIS** | **Y/N WHO_____** | **ASTHMA/HAY FEVER** | **Y/N WHO_____** |
| **BACK PAIN/CONDITIONS** | **Y/N WHO_____** | **BURSITIS** | **Y/N WHO_____** |
| **CANCER** | **Y/N WHO_____** | **DIABETES** | **Y/N WHO_____** |
| **DISC CONDITION** | **Y/N WHO_____** | **EMPHYSEMA** | **Y/N WHO_____** |
| **EPILEPSY** | **Y/N WHO_____** | **FIBROMYALGIA** | **Y/N WHO_____** |
| **HEADACHES** | **Y/N WHO_____** | **HEART CONDITIONS** | **Y/N WHO_____** |
| **HIGH BLOOD PRESSURE** | **Y/N WHO_____** | **KIDNEY CONDITIONS** | **Y/N WHO_____** |
| **LIVER CONDITION** | **Y/N WHO_____** | **LUNG CONDITION** | **Y/N WHO_____** |
| **NEURITIS** | **Y/N WHO_____** | **SCOLIOSIS** | **Y/N WHO_____** |
| **STROKE** | **Y/N WHO_____** | **SINUS CONDITION** | **Y/N WHO_____** |
| **INTESTINAL CONDITION** | **Y/N WHO_____** | **OTHER** | **Y/N WHO_____** |

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**Please Circle (C) "Current by any conditions you have now or (P) "Past" the conditions you have had in the past or (I) "Intermittent" for conditions that come and go. If "Not Applicable" circle NA. Please do not leave any blank. (CONTINUE ON NEXT PAGE)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **FIBROMYALGIA** | **C** | **P** | **I** | **N/A** | **IBS** | **C** | **P** | **I** | **N/A** |
| **HIGH BLOOD PRESSURE** | **C** | **P** | **I** | **N/A** | **DIARRHEA** | **C** | **P** | **I** | **N/A** |
| **DIZZINESS/FAINTING** | **C** | **P** | **I** | **N/A** | **NAUSEA** | **C** | **P** | **I** | **N/A** |
| **INSOMNIA** | **C** | **P** | **I** | **N/A** | **FATIGUE** | **C** | **P** | **I** | **N/A** |
| **MUSCLE TENSION** | **C** | **P** | **I** | **N/A** | **DIGESTIONS PROBS.** | **C** | **P** | **I** | **N/A** |
| **ULCERS/TYPE? _____** | **C** | **P** | **I** | **N/A** | **EYE PROBS.** | **C** | **P** | **I** | **N/A** |
| **CONSTIPATION** | **C** | **P** | **I** | **N/A** | **FEMALE PROBS.** | **C** | **P** | **I** | **N/A** |
| **PROSTATE PROBS.** | **C** | **P** | **I** | **N/A** | **DIABETES/TYPE? _____** | **C** | **P** | **I** | **N/A** |
| **COLD HANDS/FEET** | **C** | **P** | **I** | **N/A** | **LOSS OF MEMORY** | **C** | **P** | **I** | **N/A** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NERVOUSNESS** | **C** | **P** | **I** | **N/A** | **DEPRESSION** | **C** | **P** | **I** | **N/A** |
| **SWEATY PALMS** | **C** | **P** | **I** | **N/A** | **DIFFICULTY BREATHING** | **C** | **P** | **I** | **N/A** |
| **LOSS OF BLADDER CONTROL** | **C** | **P** | **I** | **N/A** | **IRRITABILITY** | **C** | **P** | **I** | **N/A** |
| **EAR/HEARING PROBS.** | **C** | **P** | **I** | **N/A** | **SPEECH DIFFICULTY** | **C** | **P** | **I** | **N/A** |
| **HEART PROBS.** | **C** | **P** | **I** | **N/A** | **ANXIETY** | **C** | **P** | **I** | **N/A** |
| **FRACTURE/BROKEN BONE** | **C** | **P** | **I** | **N/A** | **STROKE** | **C** | **P** | **I** | **N/A** |
| **HYPERTENSION** | **C** | **P** | **I** | **N/A** | **CHRONIC FATIGUE SYND.** | **C** | **P** | **I** | **N/A** |

**Have you been diagnosed with any condition or are there any conditions not listed above that affect you?** _____

**Is there ANY information regarding your general health that the doctor should know about? (i.e. past surgeries, hospitalizations, fractures, accidents, etc.?)**_____

**Are you currently taking any prescription medication, over-the-counter meds or natural supplements such as vitamins or herbs? Please list all below:**

| **Name/Describe** | **Purpose/ Reason** | **Length of Time Taken** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |

**Have you ever suffered from a stroke? Y N Have you ever had spinal surgery? Y N**
**Have you had any surgery in the past five years? Please include all procedures even knee scoping, dental surgery, etc.?** _____

## Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

| _____ | _____ | _____ |
|---|---|---|
| Print Patient Name | Patient's Signature | Date |
| _____ | _____ | _____ |
| Guardian's Name | Guardian's Signature | Date |

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and I give my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle_____

Signature_____ Date _____