Sleigh Family Chiropractic

PATIENT INFORMATION

Name: _____

What You Prefer to be Called: _____

Birth Date: _____/_____/_____ **Age:** _____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: ( ) _____
Email Address: _____

❑ I would like to opt out of receiving SMS messages and appointment reminders. I understand that Sleigh Family Chiropractic will no longer be able to communicate with me through SMS.

Employer: _____ **Occupation:** _____

Marital Status: ❑ married ❑ single ❑ divorced ❑ widowed

Spouse's Name: _____ **Occupation:** _____

Children's Names and Ages: _____

Primary Care Provider's Name: _____ **Phone: ( ) _____**

Birth Care Provider's Name: _____ **Phone: ( ) _____**

EMERGENCY CONTACT

Name: _____ **Relationship to Patient:** _____

Phone Number: ( ) _____

REFERRAL (if applicable)

Referred By: _____

PAYMENT INFORMATION

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Please enter the following information **in relation to the insurance holder**.

Insured's Name: _____ **Insured's Birth Date:** _____/_____/_____

Insurance Company: _____ **Member ID:** _____

❑ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

CURRENT CONDITION

Have you had previous chiropractic care? If so, when? _____

Reason for visit: _____

When did your symptoms appear? _____

How did this condition develop? (fall, accident, gradual, sudden, etc.) _____

Is your condition getting worse over time? ❑ YES ❑ NO

Have you had the same/similar problems before? ❑ YES ❑ NO

Have you seen other doctors for this complaint? ❑ YES ❑ NO

Name of Doctor: _____

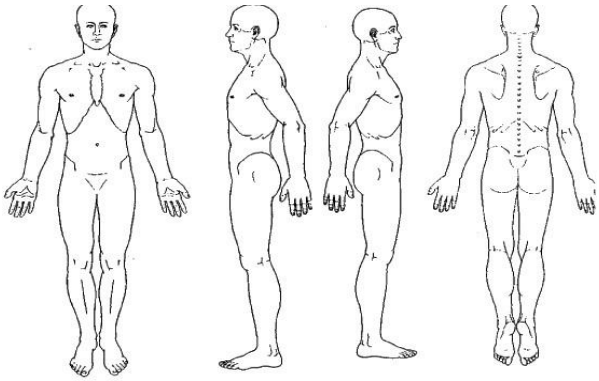
What percent of waking hours does it affect you? ❑less than 25% ❑25% ❑50% ❑75% ❑100%

The condition interferes with: ❑Work ❑Sleep ❑Daily routines ❑Recreation ❑Other: _____

Activities which are painful: ❑Standing ❑Sitting ❑Lying down ❑Walking ❑Bending

Type of pain: ❑Sharp ❑Throbbing ❑Numb ❑Aching ❑Shooting ❑Burning ❑Tingling ❑Cramping ❑Stiff ❑Swelling

PAIN LOCATION



HEALTH HISTORY

Please indicate if you have any of the following diseases/medical conditions. If the condition happened in the past, indicate by marking with a "P".

( ) Allergies	( ) Epilepsy	( ) Jaw Pain	( ) Psychiatric Care
( ) Ankle/Foot Pain	( ) Fractures	( ) Knee/Leg Pain	( ) Sciatica
( ) Anemia	( ) Headaches	( ) Menstrual Problems	( ) Scoliosis
( ) Arthritis	( ) Heart Attack	( ) Migraines	( ) Seizures
( ) Artificial Bones/Joints	( ) Heart Disease	( ) Miscarriage	( ) Shoulder Pain
( ) Asthma	( ) Heart Murmur	( ) Multiple Sclerosis	( ) Sinus Problems
( ) Back Pain	( ) Hernia	( ) Neck Pain	( ) Substance Abuse
( ) Cancer	( ) Herniated Disc	( ) Osteoporosis	( ) Stomach Pain
( ) Congenital Heart Defect	( ) High Cholesterol	( ) Pacemaker	( ) Stroke
( ) Diabetes	( ) High/Low Blood Pressure	( ) Parkinson's	( ) Thyroid Problems
( ) Dizziness	( ) Hip Pain	( ) Pelvic Pain	( ) Whiplash
( ) Ear Problems	( ) Irritable Bowel Syndrome	( ) Prostate Problems	( ) Wrist/Arm/Elbow Pain

Please list any other medical condition(s) you have: _____

_____

Please list all medications you are taking (prescription & non-prescription): _____

_____

Are you under the care of another healthcare provider? ❑ YES ❑ NO

If yes, please provide name(s) and type(s) of doctor: _____

_____

Please list anything you may be allergic to: _____

_____

Please list any previous surgeries/procedures with dates:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any and all accidents with dates (care accidents, falls, broken bones, concussions, etc.):

_____ Date: _____

_____ Date: _____

_____ Date: _____

LIFESTYLE

How would you rate your diet? ❑Excellent ❑Good ❑Fair ❑Poor

Do you exercise regularly? ❑YES ❑NO

If yes, how often? _____

Do you wear: ❑Heel lifts ❑Sole lifts ❑Arch supports ❑Custom orthotics

What is the age of your mattress? _____ **Is it comfortable?** ❑YES ❑NO

Work Habits: ❑Sitting ❑Standing ❑Repetitive bending ❑Light labor ❑Heavy labor

Other Habits: ❑Smoking – frequency: _____ ❑Drinking – frequency: _____

❑Caffeine – frequency: _____ ❑Stress – reason: _____

CURRENT PREGNANCY

How many weeks pregnant are you? _____ weeks **Date of missed period:** _____/_____/_____

How many pregnancies have you had previously? _____ **How many miscarriages?** _____

Have you had any trauma (falls, accidents) during this pregnancy? _____

_____

Please list any medications taken during pregnancy: _____

_____

Have you ever had surgery in the genital region? ❑YES ❑NO

If yes, please describe: _____

Do you smoke or drink alcohol? ❑YES ❑NO

Do you have a birth plan? ❑YES ❑NO

The birth will be assisted by: ❑Midwife ❑OB ❑Doula ❑Other ❑Undecided

Where do you plan on delivering? _____

Are you OK with the use of the following: ❑Epidural ❑Pitocin ❑Vaccinations at birth ❑Ultrasounds

Are you taking a childbirth education class? _____

How many ultrasounds have you had? _____

Please describe your diet: _____

What is your current living situation (married, single, other children in the home, smokers in the home, etc.)? _____

Rate your stress on a scale of 1-10, with 1 being the least amount of stress: _____

PREVIOUS BIRTH HISTORY (if applicable)

Place of Birth: _____

Delivering Practitioner: ❑Midwife ❑OB/GYN ❑Other

Position of Delivery: ❑On your back ❑On your side ❑Kneeling ❑Squatting ❑Other

Presentation of Baby: ❑Normal ❑Posterior ❑Breech ❑Facial ❑Brow

Was labor induced? ❑YES ❑NO

If yes, what type? _____

Were your membranes ruptured by your provider? ❑YES ❑NO

Did you receive pain medication/anesthesia? ❑YES ❑NO

If yes, what type? _____

Did you deliver vaginally? ❑YES ❑NO

Were operative devices used? ❑YES, circle which: forceps vacuum ❑NO

Was there injury to the baby? ❑YES ❑NO

- We invite you to discuss with us any questions regarding our services. The best health services are based on a mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date: _____/_____/_____**