Welcome (Ages 6-17)

Crouch FAMILY CHIROPRACTIC

Patient Information	Today's Date:

Birth Date:_____ Sex: ☐ Male ☐ Female SSN_____

Last Name _____ First Name _____ Middle Initial _____Nickname _____

Address: _____ City: _____ State: _____ Zip _____

Phone # (Best to Reach): _____Phone (Other): _____Email:_____

Referred By _____Spoken Language:_____ Race:_____ Ethnicity:_____

Emergency Contact_____Phone Number: _____Would you like to receive our newsletter? ☐ Yes ☐ No

Method of Payment: (Please circle) Insurance, Self Pay, Care Credit, Med-pay, Other _____

Have you ever had chiropractic care before? **Y / N** For what problem _____ Were the results satisfactory? **Y / N**

When was the last time you had spinal x-rays or MRI?_____ Primary Doctor:_____ OB/GYN:_____

The reason I am here is because I want: **(Please check below all that apply)** Females: Are you pregnant? Yes / No / I don't know

☐ Relief ☐ Corrective Care ☐ To be healthy ☐ I want the Doctor to recommend what is best for my health condition

Mother's Name: _____ Father's Name: _____ Guardian _____

Parent's Signature for Consent to Evaluate Minor: _____

We want you to have a copy of the patient's "Summary of Patient Health Information"
This is specific health history information (from our office) and keeps you up to date on what we have on file.
You will get one email with a secure link to our software. Use this link anytime you want to access your health information.
Please make sure we have your email address (above).
You will need a password to access your account. This will be your last name (lowercase) + last 4 digits of SS# _____

Any Surgeries	Trauma History	Current Meds	Allergies	Exercise	Social History
	Car Accidents	Please list your medications and dosage.	List any allergies and Severity. (Mild, Mod, Sev)	Do You Exercise? ☐ Yes ☐ No	**Please Check One:**
				If yes, what kind?	Current Smoker ___
					Former Smoker ___
					Never Smoked ____
Implants	Serious Illnesses			How Often?	Smokeless Tobacco (Dip or Chew) ☐ Yes ☐ No
					Caffeine ☐ Yes ☐ No
Broken Bones	**Please List Your Vitamins**			Other Hobbies	Alcohol ☐ Yes ☐ No

Family History:

Did / Does your Mother (M) or Father (F) have any of the following?

☐ High Blood Pressure (M / F) ☐ Heart Attack (M / F) ☐ Emphysema (M / F) ☐ Seizures – Convulsions (M / F)

☐ Asthma (M / F) ☐ Diabetes (M / F) ☐ Kidney Disease (M / F) ☐ Pace Maker (M / F)

☐ Ulcers (M / F) ☐ Arthritis (M / F) ☐ Stroke (M / F) ☐ Digestive Troubles (M / F)

☐ Mental Illness (M / F) ☐ Thyroid (M / F) ☐ Cancer (M / F) ☐ Osteoporosis (M / F)

Please list any other health challenges / problems in your family history:

_____

_____

Patient Initials _____

Have you had or do you have any of the following symptoms which are or have been significant distress to you? Please indicate with the letter **N** if you have these conditions NOW (within the past 12 months) or **P** if you have ever had this conditions in the past (a year or longer). Leave blank if it has never been affected.

	Now N	Past P		Now N	Past P
Headaches			Frequent Loss of Balance		
Neck Pain			Fainting		
Stiff Neck			Loss of Smell		
Sleeping			Problems / Loss of Taste		
Back			Diarrhea with Pain		
Nervousness			Feet Cold		
Tension			Hands Cold		
Irritability			Arthritis		
Chest Pains			Muscle Spasms		
Dizziness			Frequent Colds		
Shoulder/Neck/Arm Pain			Stomach Upset		
Pins & Needles in Arms			Constipation		
Pins & Needles in Legs			Cold Sweats		
Numbness in Fingers			Fever		
Numbness in Toes			Sinus Problems		
High Blood Pressure			Diabetes		
Difficulty Urinating			Hemorrhoids		
Allergies			Leg Cramps		
Weakness in Arms			Colitis		
Weakness in Legs			Gall Bladder		
Shortness of Breath			Indigestion		
Fatigue			Belching		
Depression			Vomiting		
Lights Bother Eyes			Shoulder Pain		
Loss of Memory			Swelling Joints		
Ears Ring			Knee Pain		
Face Flushed			Hayfever		
Buzzing in Ears			Menstrual Difficulties		

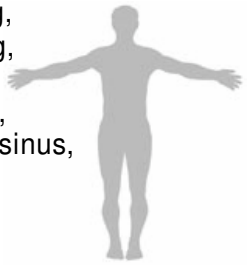
Activities of Daily Living:

Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Sleeping:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Running:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Climbing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Carrying:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Pushing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Reading:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Watching TV:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Doing Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Gardening:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Playing Sports:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Working:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Dancing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Change Positions: (Sitting to Standing)	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Rolling Over:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)
Other: _____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Moderate** Painful (Limited)	☐ **Severe** Painful (Unable to do)

Please Fill Out the Information Below and Circle ALL that Apply to the Problems You Experience

Patient Initials:

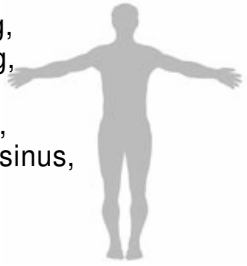
Main Health Concern 1) _____

Onset Date	Type:	Quality	Front	Location	Back	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,				Constant,	Mild,
	Swelling	throbbing, crushing,				Frequent	Tolerable ,
Exacerbated	Muscle Spasms	stabbing, local,				Intermitt	Moderate ,
	Headache	radiating, migraine,				Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,				Infrequent	Disabling
	Stiffness	Other				% Awake	
	Tingling, Weakness					Time_____	

Main Health Concern 2) _____

Onset Date	Type:	Quality	Front	Location	Back	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,				Constant,	Mild,
	Swelling	throbbing, crushing,				Frequent	Tolerable ,
Exacerbated	Muscle Spasms	stabbing, local,				Intermitt	Moderate ,
	Headache	radiating, migraine,				Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,				Infrequent	Disabling
	Stiffness	Other				% Awake	
	Tingling, Weakness					Time_____	

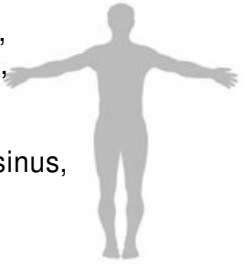
Main Health Concern 3) _____

Onset Date	Type:	Quality	Front	Location	Back	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,				Constant,	Mild,
	Swelling	throbbing, crushing,				Frequent	Tolerable ,
Exacerbated	Muscle Spasms	stabbing, local,				Intermitt	Moderate ,
	Headache	radiating, migraine,				Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,				Infrequent	Disabling
	Stiffness	Other				% Awake	
	Tingling, Weakness					Time_____	

Main Health Concern 4) _____

Onset Date	Type:	Quality	Front	Location	Back	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,				Constant,	Mild,
	Swelling	throbbing, crushing,				Frequent	Tolerable ,
Exacerbated	Muscle Spasms	stabbing, local,				Intermitt	Moderate ,
	Headache	radiating, migraine,				Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,				Infrequent	Disabling
	Stiffness	Other				% Awake	
	Tingling, Weakness					Time_____	

Main Health Concern 5) _____

Onset Date	Type:	Quality	Front	Location	Back	Timing	Severity
_____	Pain, Numbness	Sharp, Dull, aching,				Constant,	Mild,
	Swelling	throbbing, crushing,				Frequent	Tolerable ,
Exacerbated	Muscle Spasms	stabbing, local,				Intermitt	Moderate ,
	Headache	radiating, migraine,				Occasion	Severe,
_____	Tightness	tension,hormonal, sinus,				Infrequent	Disabling
	Stiffness	Other				% Awake	
	Tingling, Weakness					Time_____	