MISSION WELLNESS
CHIROPRACTIC
ACUPUNCTURE • MASSAGE THERAPY

Please fill out our Health Record as completely and accurate as possible.
If you have any questions, please don't hesitate to ask one of our front desk staff.
It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with natural care.

First Name _____ **MI** _____ **Last Name** _____

Street Address _____

City _____ **State/Province** _____ **Zip Code** _____

Cell Phone _____ **Home Phone** _____

Email _____ **Date of Birth** _____

Social Security # _____ **Gender** ◯ Male ◯ Female ◯ Other

Marital Status
◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Seperated

EMPLOYER INFORMATION:

Employer _____

Type of Work _____

REFERRED BY:

_____

EMERGENCY CONTACT:

Relationship _____ **Best phone number** _____

First Name _____ **Last Name** _____

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REASON FOR VISIT:

Is the purpose of this appointment related to:

- ◯ Job
- ◯ Fall
- ◯ Other
- ◯ Sports
- ◯ Chronic Discomfort
- ◯ Auto accident
- ◯ Home Injury

If job related, have you made a report of your accident to your employer?

◯ Yes ◯ No

When did this condition begin?

_____

Has this condition

◯ Gotten worse ◯ Stayed Constant ◯ Comes and goes

Does this condition interfere with

- ◯ Work
- ◯ Daily Routine
- ◯ Sleep
- ◯ Other activities

Has this condition occurred before?

◯ Yes ◯ No

Explain

_____

Have you seen other doctors for this condition?

◯ No ◯ Yes

Doctor's Name (s)

_____

Type of Treatment

_____

Results

_____

EXPERIENCE WITH CHIROPRACTIC:

Who referred you to this office?

_____

Have you been adjusted by a chiropractor before?

◯ Yes ◯ No

Reason for those visits?

_____

Doctor's Name

_____

Approximate date of last visit?

_____

Have you had any recent slips, falls, or accidents? ◯ Yes ◯ No

Have you had any surgeries? ◯ Yes ◯ No

If yes, please describe: _____

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HEALTH HABITS

Do you smoke? ◯ Yes ◯ No

Do you drink alcohol? ◯ Yes ◯ No

Do you drink coffee? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, $ care plan.

- ☐ Severe or Frequent Headaches
- ☐ Cancer
- ☐ Pain Between the Shoulders
- ☐ Lower Back Pain
- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Psychiatric Problems
- ☐ Asthma
- ☐ Venereal Disease
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Sinus Problems
- ☐ Loss of Sleep
- ☐ Frequent Neck Pain
- ☐ Digestive Problems
- ☐ Thyroid Problems
- ☐ Heart Surgery/Pacemaker
- ☐ Difficulty Breathing
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Shingles
- ☐ Dizziness
- ☐ Hepatitis
- ☐ Numbness or Pain in Arms/ Legs/Hands
- ☐ Ulcers/Colitis
- ☐ Kidney Problems
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Alcohol/Drug Abuse
- ☐ Diabetes
- ☐ Chemotherapy

FOR WOMEN ONLY:

Are you pregnant? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No

Do you experience painful periods? ◯ Yes ◯ No

Do you have irregular cycles? ◯ Yes ◯ No

Authorization and Consent for Care

I have read and attest to understanding the provided risks associated with receiving and not receiving chiropractic care. **I hereby give my consent and authorize the provider to work** with my condition through the use of their licensed trade as he or she deems appropriate with appropriate patient's consent. The provider will not be held responsible for any pre-existing medical conditions nor for any previous medical diagnosis. All patients' medical records and rights will be protected according to the law under HIPAA regulations. I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment at time of service. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Dated	DATED
PATIENT NAME	DOCTOR NAME
SIGNATURE (Over 18 or legal guardian)	SIGNATURE