



**3. How often do you experience your symptoms?**

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

**4. How would you describe the type of pain?**

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Electric like with motion
- Other: \_\_\_\_\_

**5. How are your symptoms changing with time?**

- Getting Worse
- Not Changing
- Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0      1      2      3      4      5      6      7      8      9      10 (Please circle)

**7. How much has the problem interfered with your work?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**8. How much has the problem interfered with your social activities?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**9. Who else have you seen for your problem?**

- Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other: \_\_\_\_\_
- No one

**10. How long have you had this problem?** \_\_\_\_\_

**11. How do you think your problem began?** \_\_\_\_\_

**12. Do you consider this problem to be severe?**

- Yes
- Yes, at times
- No

**13. What aggravates your problem?** \_\_\_\_\_

**14. What makes your problem feel better?** \_\_\_\_\_

**15. What concerns you the most about your problem (Please Pick Only One)?**

- Could be Serious
- Affecting Mental Outlook
- Not Going Away
- Affecting Relationships
- Getting Worse
- Affecting Leisure
- Affecting Work
- Other: \_\_\_\_\_
- Affecting Sleep

**16. What is your: Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**17. How would you rate your overall Health?**

- Excellent
- Very Good
- Good
- Fair
- Poor

**18. What type of exercise do you do?**

- Strenuous
- Moderate
- Light
- None

**19. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus
- ALS

**20. What impact do you believe your family history has on your own health?**

- None       Mild       Moderate       Extreme

**21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<b>For Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**22. List any prescription medications or over-the-counter medications you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

**23. List any nutritional supplements you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

**24. List all surgical procedures you have had:**

\_\_\_\_\_

\_\_\_\_\_

**25. What activities do you do at work?**

<input type="checkbox"/> <b>Sit:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Stand:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Computer work:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>On the phone:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Drives:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Walk</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Other:</b>	<input type="checkbox"/> Manual Labor	<input type="checkbox"/> Reads a lot	<input type="checkbox"/> Travels a lot

**26. What activities do you do outside of work?** \_\_\_\_\_

**27. Have you ever been hospitalized?**  No       Yes, if yes, why \_\_\_\_\_

**28. Have you seen a chiropractor before?**  No       Yes

If yes, who: \_\_\_\_\_ how long ago: \_\_\_\_\_ results were:  Good     Mixed     Bad

**29. Have you had significant past trauma?**  No       Yes, if yes list: \_\_\_\_\_

**30. Anything else pertinent to your visit today?** \_\_\_\_\_

I authorize this office to release any information requested by my insurance company or other health care individuals to document my claim for benefits or assist in further health care purposes. The above information was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health status or financial status.

**Patient (or Guardian) Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Consent to evaluate and adjust a minor child

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## Consent for Treatment

I, the undersigned, hereby authorize the Doctors of Porter Family Chiropractic and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness \_\_\_\_\_

## HIPPA INFORMATION

*DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:*

### SPECIFIC AUTHORIZATIONS

1. I give permission to Porter Family Chiropractic use my address, phone number and clinical records to contact me with birthday cards, newsletters, patient letters, thank-you cards, first adjustment calls, testimonials and information about treatment alternatives or other health related information.
2. By signing this form you are giving Porter Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

### RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Porter Family Chiropractic. The written notice must contain the following information:

Your Name, Social Security Number and Date of Birth; A Clear Statement of Your Intent to Revoke This AUTHORIZATION; The Date of Your Request and Your Signature.

I have read and agree to the financial policy and Hipa privacy policy set above. Furthermore should I for any reason, discontinue care, I understand that the entire balance for professional services rendered to date will be due within 30 days. I agree that you may release my information to my insurance agent / adjuster or their agents regarding my care in this office. I also understand that the records including x-rays are a permanent record and are the property of Porter Family Chiropractic. Copies are available at a nominal charge. A copy of this agreement will serve as the original. This AUTHORIZATION is requested by Porter Family Chiropractic for its own use or disclosure of PHI. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Porter Family Chiropractic will not refuse to provide treatment.

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Signature of Patient / Guardian*

\_\_\_\_\_  
Witness

**Your Family and Your Health are in Great Hands!**