Symptoms:

Reason for visit:_____When did you first notice the symptoms?_____
Is this condition getting progressively worse?_____
Where specifically is the problem(s) located?_____
Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
Rate the severity of your pain (1 mild pain or discomfort to 10 – severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?_____
What treatment have you already received for your condition?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other_____
Name and address of other doctor(s) who have treated you for your condition:_____

Health History:

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other_____
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	_____
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	_____

Dates of last exams:_____
(Women) Are your pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
List any types of surgeries which you have had and the dates which they occurred:_____
Please list all medications you are currently taking:_____
Allergies:_____

Daily Habits:

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)
What vitamins do you currently take?_____
What kind of other nutritional supplements do you take (if any)?_____
Do you smoke? ☐ No ☐ Yes How much per day?_____
How much liquor do you consume on a weekly basis?_____
How much coffee or caffeinated beverages do you consume on a daily basis?_____

Certification and Assignment:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. Barry Ward Sauls all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease."

Thomas Edison

Patient Information:

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name: _____ Date: _____ SS/HIC/Patient ID#: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Female ☐ Male Birth Date: _____ E-Mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

Whom May We Thank For Referring You To Us? _____

Person to Contact in Case of Emergency: _____ Phone: _____

Responsible Party:

Name of Person Responsible For This Account: _____

Relationship to Patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work Phone: _____

How Did You Hear About The Chiropractic and Acupuncture Wellness Center?

_____ Friend / Relative

_____ Advertisement / Town And Country

_____ Advertisement / Shopper's Guide

_____ Website

_____ Other