East Stadium Chiropractic Wellness Center

Please print clearly and fill in completely

Print Name ________________________________ Circle: Male / Female Date _____/_____/_____
Street Address ________________________________ City ____________________ State ___ Zip ________
Date of Birth ____/____/____ Social Security # ___________________Email ____________________________
Cell Phone ( ) ______________Home Phone ( ) ______________Work Phone ( ) ______________
Do you have insurance that you believe may cover part of your chiropractic care?
Please Check ✔ Yes ❐ No ❐ Name or type of insurance: __________________ ID # ___________________

Health History:

Give reason(s) for seeking chiropractic care: ____

____

Describe any health problems, including how long you've had them: ________________________________

____

Are you under the care of any other doctor? Yes ❐ No ❐ If Yes, explain conditions being treated for:

____

List any current Medications: ____
List any past surgeries & date: ____
List any past accidents & dates: ____

____

Did/do you smoke? Yes/No Did/do you drink alcohol? Yes/No Do you primarily eat whole foods? Yes/No
On a scale of 1-10, describe your stress level (1=none / 10=extreme): Occupational _____ Personal _____

Your Birth Record:

Location: Home / Hospital Form of Delivery: Vaginal / C-Section / Forceps / Vacuum / Induced
Complications during/after birth: ____

Personal & Family History:

Your Occupation: ___________________ Work Duties ____
Marital Status _____________ Spouse's health status ____
Children's ages and health status: ____
FEMALES: Please Check One ✔ Is there a possibility of you being pregnant? Yes ❐ No ❐

Chiropractic History:

Have you ever been to a Chiropractor before? Yes ❐ No ❐ If Yes, Doctor's Name: _____________________
Date of last chiropractic visit __________ Reason for care ____
Are other family members under chiropractic care? Yes ❐ No ❐ Who? ________________________________

Rate Your Overall Health:

At East Stadium Chiropractic we are dedicated to achieving the goal of total lasting health for each of our practice members. To better help you achieve this, we need to understand how you view your overall health. Please rate the following on a scale of (P)oor, (G)ood, or (E)xcellent:
Diet___ Exercise___ Sleep___ General Health___

Referrals:

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us! Please let us know where you heard about our clinic, or who referred you: ______________________________________
Would you like to subscribe to our free wellness newsletter? Yes / No

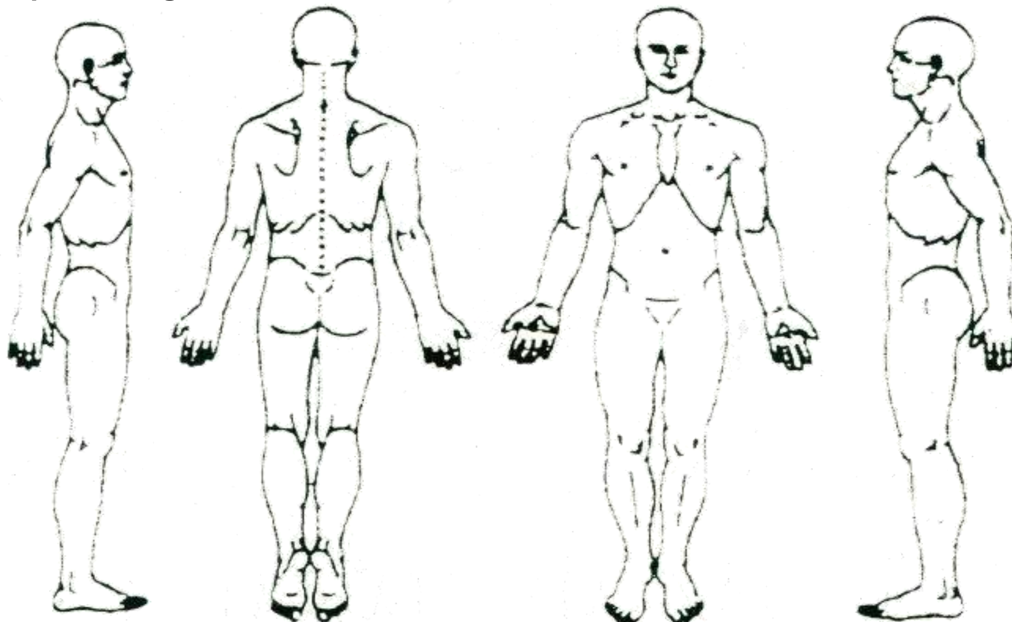
Please Fill in Below

If you currently or recently have suffered from the following, ***Please Check*** ✔

Condition, Symptom Or Problem	Constantly / Frequently	Sometimes / Occasionally
Headaches	❐	❐
Migraines	❐	❐
Neck Pain or Stiffness	❐	❐
Shoulder Pain or Stiffness	❐	❐
Arm / Hand Paint or Stiffness	❐	❐
Arm / Hand Numbness / Tingling	❐	❐
Cold Hands	❐	❐
Mid Back Pain or Stiffness	❐	❐
Abdominal Pain	❐	❐
Low Back Pain or Stiffness	❐	❐
Leg / Foot Pain or Stiffness	❐	❐
Pelvic / Hip Pain or Stiffness	❐	❐
Leg / Foot Pain or Stiffness	❐	❐
Leg / Foot Numbness or Tingling	❐	❐
Cold Feet	❐	❐
Arthritis	❐	❐
Disc Problems	❐	❐
Dizziness / Vertigo	❐	❐
Loss of Balance	❐	❐
Decreased Concentration	❐	❐
Loss of Sight	❐	❐
Loss of Hearing	❐	❐
Loss of Taste	❐	❐
Loss of Smell	❐	❐
Light Bothers Eyes	❐	❐
Weakness	❐	❐
Fatigue	❐	❐
Difficulty Sleeping	❐	❐

Condition, Symptom Or Problem	Constantly / Frequently	Sometimes / Occasionally
Recent Weight Gain	❐	❐
Recent Weight Loss	❐	❐
Swelling	❐	❐
Loss of Consciousness	❐	❐
Seizure	❐	❐
Acid Reflux	❐	❐
Diarrhea	❐	❐
Constipation	❐	❐
Mental Stress	❐	❐
Frequent Colds/Flus	❐	❐
Ear Infections	❐	❐
Sore Throat	❐	❐
Sinus Problems	❐	❐
Nose Bleeds	❐	❐
Cough	❐	❐
Fever	❐	❐
Chest Pains	❐	❐
Anxiety	❐	❐
Depression	❐	❐
Allergies	❐	❐
Asthma	❐	❐
Heart Problems	❐	❐
Diabetes	❐	❐
Hypoglycemia	❐	❐
Urinary Problems	❐	❐
Osteoporosis	❐	❐
Cancer	❐	❐
Other ___________________	❐	❐

Please mark the problem areas below and give a brief description of the symptoms you are experiencing in those areas:



Comments: _________________
____
____
____
____
____
____

The statements made on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation.

____
Signature

____
Date

** For Minors (Under 18): I am the legal guardian of ________________________, and hereby authorize chiropractic care as deemed necessary by East Stadium Chiropractic Wellness Center.

Relationship ________________________ Signature ____________________________________ Phone ____________________

☐ Completed ☐DXs entered File # ___________

East Stadium Chiropractic Wellness Center

EHR History & Examination

Patient Name: ____ Date: ______________

1. DEMOGRAPHICS

A. Ethnicity ☐ Non-Hispanic ☐ Hispanic ☐ Don't know / Prefer not to say

B. Preferred Language ☐ English ☐ Spanish ☐ Don't know / Prefer not to say
☐ Other_______________________

C. Race ☐ White/Caucasian ☐ African American ☐ Don't know / Prefer not to say
☐ Native American ☐ Hawaiian/Pacific ☐ Don't know / Prefer not to say
☐ Other____________________________

2. Would you like to have log in instructions sent to your email to have access to your medical record?
☐ YES ☐ NO Email ____

*_____ (Please Initial) *I hereby give my consent to have my health records available to me via a secure, web-based portal.*

3. Are you taking any medications? ☐ YES ☐NO
If yes, please list medications (be specific) you are currently taking along with dosage.
**If you have a med list, we can copy it for you instead.*

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

4. Are you allergic to any Medications? ☐YES ☐NO
If yes, please list medications you are allergic to and the problem experienced, along with the level of severity (mild, moderate, or severe):

______________________________________ ______________________________________
______________________________________ ______________________________________

5. Do you smoke now? ☐YES ☐NO
Have you ever been a smoker? ☐YES ☐NO
Do you use any form of Tobacco? ☐YES ☐NO

If a current tobacco user, please complete the following:
What type:___________________________
How Much: __________________________
Have you tried to quit? ☐YES ☐NO
What methods did you use?
____

To be completed in office:
Height _______ Weight _______
* *Vital Signs* : BP_____/_____