Welcome to Uptown Natural Care Center!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to reach out to our office.
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 Chiropractic care.

About this Patient

First Name _____ **Last Name** _____ **Date of Birth** _____

Street Address _____

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

Cell Phone _____ **Phone** _____

Gender _____

Marital Status

◯ Married ◯ Single
◯ Divorced/Separated ◯ Other

Employer Information

Employer _____

Occupation _____

Reason for this Visit

Is the purpose of this appointment related to:

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

Please explain. _____

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 ☐ Sleep
☐ Daily Routine ☐ Other activities

Has this condition occurred before?

◯ Yes ◯ No

Explain

_____

Have you seen other doctors for this condition?

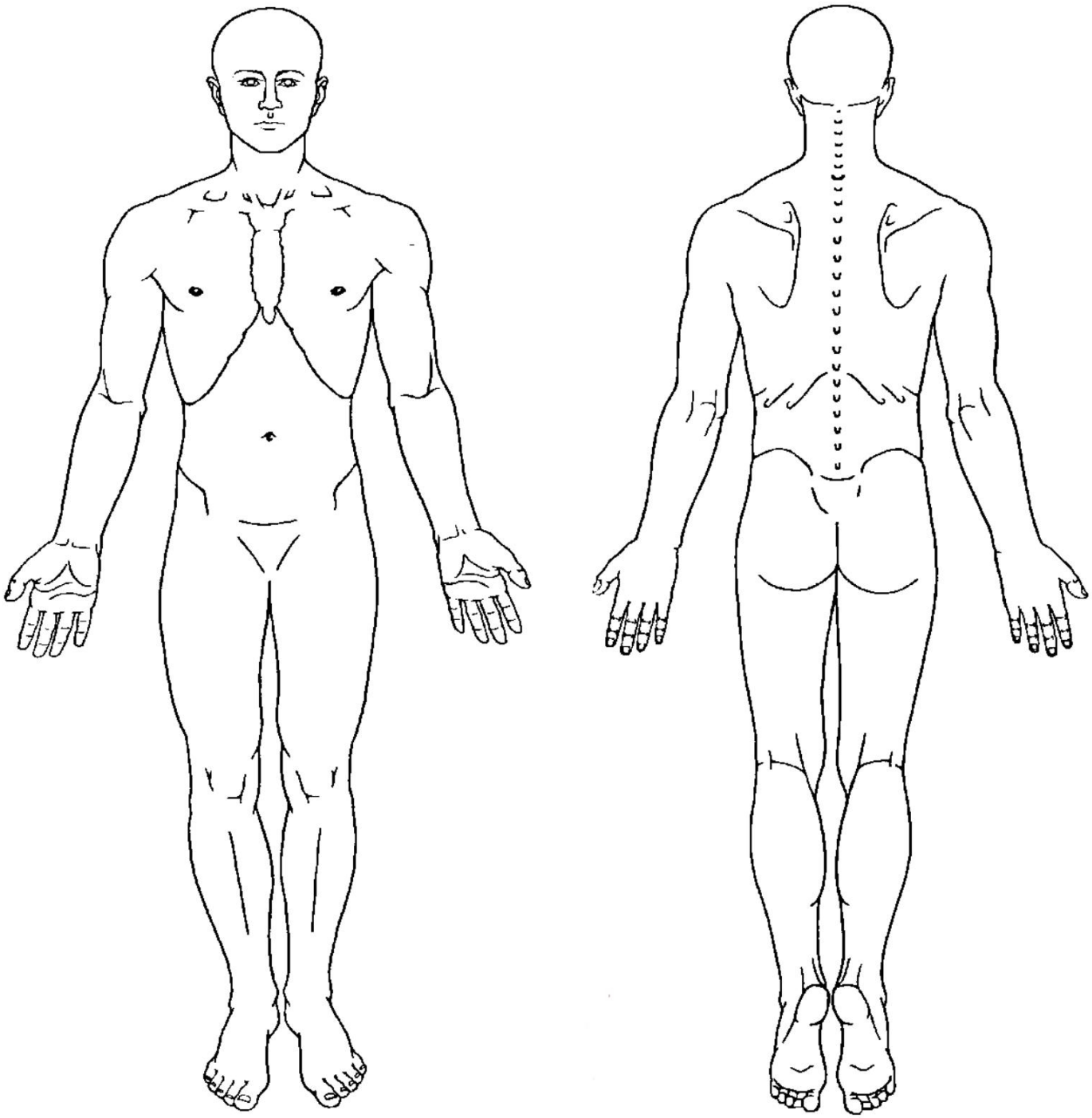
◯ No ◯ Yes

Doctor's Name (s)

_____

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Primary Complaint (s):

Overall frequency of complaint (choose one)

◯ Constant - 100% of the time ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Overall intensity of complaint 1-10 (1 = Low, 10 = Severe)

◯ Minimal (An annoyance but has no effect on activity) ◯ Slight (Tolerable with some impairment to activity)

◯ Moderate (Tolerable with marked impairment of activity) ◯ Severe (Intolerable and cannot perform any activities)

What aggravates the problem?

What relieves the problem?

Experience with Chiropractic

Who referred you to this office?

_____

Have you been adjusted by a chiropractor before?

◯ Yes ◯ No

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others choose a preventative approach. Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the level of care desired so that we may be guided by your preferences whenever possible.

Relief Care: Symptomatic relief of pain or discomfort with the least amount of treatment possible. (Covered by most insurance)

☐ Yes

Corrective Care: Pain relief and treatment to stabilize and retrain tissues for long lasting improvement. (Covered by some insurance plans. If not covered by insurance this option is $65/visit)

☐ Yes

Preventative Care: Pain relief, corrective care, and also treatments to prevent future episodes. (This stage is not covered by insurance plans and costs $65/visit)

☐ Yes

Health Habits

Do you smoke?

◯ Yes ◯ No

Do you drink alcohol?

◯ Yes ◯ No

Do you drink coffee?

◯ Yes ◯ No

Do you exercise regularly?

◯ Daily ◯ Moderately ◯ 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 and the possibility of being accepted for care.

Health Conditions:

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

Current Prescriptions:

FOR WOMEN ONLY:

Are you pregnant?
◯ Yes ◯ No

Are you nursing?
◯ Yes ◯ No

Are you taking birth control?
◯ Yes ◯ No

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

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. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. 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.

Emergency Contact

First Name _____ **Last Name** _____

Relationship _____ **Cell Phone** _____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself . I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Carrier: _____ **Insured ID #** _____ **Group #** _____

Signature _____ **Date Signed** _____

Printed Name _____ **Email** _____