

Demographics

Full Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Best Phone #: _____

VA patients and Auto patients only - Social Security # _____

Marital Status: Single Married Separated Divorced Widowed Other

Spouse's Name: _____ Number of Children: _____

It is our mission to keep our community healthy and thriving by empowering you to achieve your greatest health potential! Who can we thank for referring you to our office?

Name: _____ or Event Location: _____

Word of Mouth Google Facebook RHC Website Workshop Outside Talk

Current Health Concern

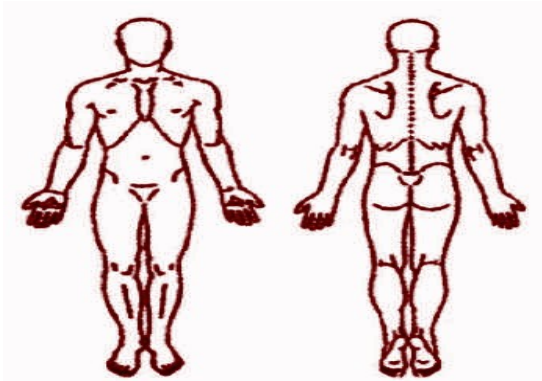
Main Complaint: _____

How Long have you had this complaint?

Less than 5 days (Acute) 5-30 days (Sub Acute) More than 30 days (Chronic)

Have you recently been in a car accident? Yes or No If so, when? _____

On the body diagrams below, please indicate your areas of concern by labeling with the appropriate descriptions:



- P - Pain
- N - Numbness
- T - Tingling
- S - Shooting

On a Scale of 1 to 10 with 10 being the most severe, how would you rate your current level of discomfort? _____

Body Measurements

Health challenges always have root causes. In this section, we will be gathering basic lifestyle and health history information so we can understand how best to help you heal.

Height (in): _____ Weight (lbs): _____ Gender: _____

Health History Review

Have you been diagnosed with, or currently taking medication for any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine/Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Neurodegenerative |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |

Current Medications:

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Insulin/Diabetes | <input type="checkbox"/> Advil/Tylenol | <input type="checkbox"/> Sleep Aids |
| | | <input type="checkbox"/> Other _____ |

Lifestyle Habits

On a scale 1-10 with 1 being poor and 10 being excellent, how would you rate your:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water _____ General Health _____

How many days a week do you do use: Alcohol _____ Smoking _____ Sodas _____ Energy Drinks _____

Occupation : _____

Describe Your Typical Day at Work:

Employer : _____

- | | |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Light Duty | <input type="checkbox"/> Heavy Duty |

The following supplements are what we call the "Core 4" because they are critical to your health, and because the research shows most Americans are deficient in them. Do you take the following daily:

Omega-3 Fish Oils	Vitamin D3	Probiotics	Multi Vit/Mineral
Yes / No	Yes / No	Yes / No	Yes / No

HIPPA and Insurance / Payment Policies

This office conforms to the current HIPAA guidelines. You can request a copy of your HIPAA policy at the front desk. I certify that I'm the patient or legal guardian listed above, I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize this office and its staff to examine and treat my condition as the doctor sees fit. I hereby authorize the doctor to release all information necessary to insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submission. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that any insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. My signature indicates I have been made aware of these policies.

Signature: _____

Date: _____