

Welcome to Crossroads Chiropractic

Today's Date: ___/___/___ Home Phone #: _____ Work Phone#: _____

Full Name: _____ What do you prefer to be called: _____

Legal Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ EMAIL: _____

Birthdate: ___/___/___ Age: _____ SS# _____

How did you learn about our office? _____

Previous Chiropractic Care? ___ Yes ___ No Approximate Last Visit Date: _____

Status: *(Please Circle)* Single Married Divorced Separated Widowed Domestic Partner

Spouse or Partner's Name: _____

Name and Ages of Children: _____

Hobbies: _____

Patient's Employer/Business: _____ Occupation: _____

Are you seeking care for a work related injury? *(Circle one)* Yes No Auto Accident? *(Circle one)* Yes No

I hereby authorize the doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize and consent that the doctor chooses and employs such assistance as she sees fit. I also understand that prior to care, full explanation of the procedures involved will be given. I agree to pay all services rendered in this office.
Signature: _____ Date: ___/___/___ Relationship to patient: _____

Please check reasons for pursuing chiropractic care:
___ *I'm continuing ongoing care from another chiropractor.*
___ *I'm interested in wellness and natural health care.*
___ *I'm concerned about my health and I'm looking for answers.*
Explain condition or symptom _____

___ *I want to improve my immune function.*
___ *I have no idea why I'm here. Please take the time to explain to me what you do.*

In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:
___ Dizziness or Fainting ___ Headache ___ Postural Imbalance ___ Arthritis ___ Asthma
___ Short Leg/Orthotics ___ Ear Infection ___ Intestinal Problems ___ Frequent Colds
___ Sinus Problems ___ High Blood Pressure ___ Bladder Problems ___ Kidney Problems
___ PMS ___ Menopausal Symptoms

Check the following conditions that YOU have or have had:
Circle conditions that are common to FAMILY MEMBERS:
___ AIDS ___ Alcoholism ___ Cancer ___ Diabetes ___ Epilepsy ___ Hyper/Hypothyroidism
___ Heart Disease ___ Lung Disease ___ Multiple Sclerosis ___ Scoliosis ___ Stroke ___ Ulcers

List Prescription or Over-The-Counter Medications now taken: _____

Known Allergies: _____

The Stress Test

The following areas of stress can cause a misaligned vertebra (subluxation).

Which do you recognize of these stresses?

Please circle when you experienced these stresses:

C (child), T (teenager), A (adult)

<u>Physical / Emotional / Chemical Stress:</u>				<u>Comments:</u>
Birth Traumas	C			
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Sitting on a Wallet		T	A	
Sleeping on Stomach		T	A	
Extensive Computer Work		T	A	
Carry Heavy Purse/Bookbag/Child		T	A	
Repetitive Lifting/ Bending		T	A	
Driving for many hours		T	A	
Continuous hours sitting/standing		T	A	
Career Stress			A	
Children Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker / Second Hand Smoke	C	T	A	Amount: _____
Poor Diet / Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount: _____
Artificial Sweetener(s)	C	T	A	
Prescription Drugs	C	T	A	
Over the counter Drugs (ex. Tylenol, Motrin)	C	T	A	

Which do you feel are your primary stresses? _____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

(Signature)

//_/
(Date)

Crossroads Chiropractic Privacy Authorization

We strive to make your experience with us exceptional. However, due to new laws passed to protect your privacy we request in writing your authorization to proceed with certain office practices. Your signature below will verify that (1) you have read the following procedures and do not object and (2) you have been given a notice of our privacy practices and an opportunity to review them.

- ★ We welcome new patients and thank referrals with their names on a dry erase board at the front desk
- ★ We use postcards and to wish you happy birthday, welcome you or remind you of an appointment
- ★ We may mail health articles, newsletters and other information directly to your home or email
- ★ We may leave a message at your home with someone or on an answering machine
- ★ We post pictures of our "Chiropractic Kids" in the kid's area and "Chiropractic Families" on the Family boards
- ★ Should you share a written testimonial with us, we may display it in binders or use it in our advertising
- ★ You will receive your chiropractic adjustments in an open adjusting area with half walls.

(Signature)

//_/
(Date)