ACTION CHIROPRACTIC CENTER

HEALTH FORM

Name_____ Email_____ Date_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Ph_____ Work Ph_____

Birth Date_____/_____/_____ SSN_____-_____-_____ Height_____ Weight_____

Employer_____ Address_____

Do you have health insurance?_____ Company Name_____

Was this the result of an auto accident?_____ Work injury_____

Other accident?_____ If yes, date_____/_____/_____

Other doctors seen for this condition_____

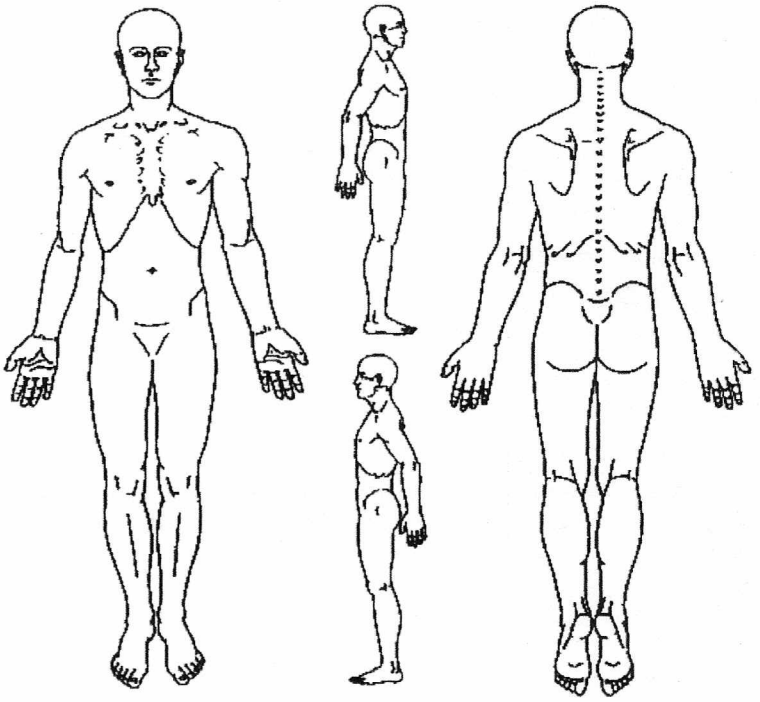
How did you hear about us?_____

Use the letters below to indicate the type and location of your sensations right now:

A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBING
O = OTHER



PHYSICAL COMPLAINT:

1. Description_____ Onset Date_____
   Scale 0-10_____ Percentage of time felt 0%-------25%-------50%-------75%-------100%
   0=Best 10=Worst

2. Description_____ Onset Date_____
   Scale 0-10_____ Percentage of time felt 0%-------25%-------50%-------75%-------100%
   0=Best 10=Worst

3. Description_____ Onset Date_____
   Scale 0-10_____ Percentage of time felt 0%-------25%-------50%-------75%-------100%
   0=Best 10=Worst

STRESS INDEX

Circle the number that bests represents you.

0=Best 10=Worst

DIET: **0 1 2 3 4 5 6 7 8 9 10**	**PHYSICAL STRESS:** **0 1 2 3 4 5 6 7 8 9 10**	**ACTIVIY LEVEL:** **0 1 2 3 4 5 6 7 8 9 10**
QUALITY OF SLEEP: **0 1 2 3 4 5 6 7 8 9 10**	**MENTAL STRESS:** **0 1 2 3 4 5 6 7 8 9 10**	**TOTAL:**

The following lists are a variety of conditions that patients may experience. Check the box next to each condition that applies to you.

Skeletal
- □ neck pain
- □ mid back pain
- □ low back pain
- □ headaches
- □ pain down arms
- □ pain down legs
- □ pain down arms
- □ pins & needles
- □ numbness

Cardiovascular
- □ heart problems
- □ lung problems
- □ chest pain
- □ high/low blood pressure
- □ asthma
- □ other_____

Digestive
- □ gas
- □ acid reflux
- □ stomach pains
- □ bloating
- □ vomiting
- □ constipation
- □ diarrhea

General
- □ trouble sleeping
- □ weight loss/gain
- □ loss of energy
- □ arthritis
- □ cold/hot
- □ fractures
- □ osteoporosis
- □ allergies

Family History
- □ Autoimmune disorder
- □ Arthritis
- □ Cancer
- □ Diabetes
- □ Heart disease
- □ Kidney disease
- □ Mental illness
- □ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical information to Action Chiropractic Center. I understand and acknowledge the location and accesibility to the "Notice of Privacy Practices" and have been provided with the opportunity to review it.

Print Name:_____ Date:_____/_____/_____

Signature:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. In the event that the insurance carrier does not cover services rendered, I understand that I am responsible for payment. In the event this occurs, Action Chiropractic Center will help prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to Action Chiropractic Center will be credited to my account upon receipt. Finally, I agree that if I suspend payment or terminate my care and treatment, any fees for professional services rendered will immediately be due and payable.

Print Name:_____ Date:_____/_____/_____

Signature:_____