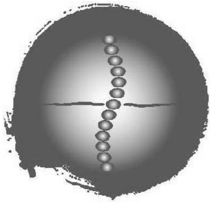

INTEGRAL CHIROPRACTIC CENTER

Confidential Personal History

Name:________________________ Date of Birth: ______________ Date: __________

Illnesses

1. If you have or had any of the following illnesses, please check the appropriate box

	Past	Current	List family members who have had these illnesses (siblings, parent, grandparent, children)
Heart Disease	q	q	
Hypertension	q	q	
Cancer	q	q	
Diabetes	q	q	
Lung Disease (asthma, etc.)	q	q	
Allergies	q	q	
Digestive	q	q	
Other:	q	q	
Other:	q	q	

Physical History

Birth Stress (if you know your birth history)

2. Was your mother outwardly ill prior to her pregnancy with you? q Yes q No
3. Did your mother have a difficult pregnancy with you? q Yes q No
4. Did your mother have any falls, accidents, or physical injuries during pregnancy? q Yes q No
5. Was your birth: q Drug-induced q Forceps or suction q Natural q Caesarean section q Cord around the neck q Prolonged q Breech q Other (please describe):

General Physical Trauma

6. Were you ever knocked unconscious? q Yes q No Comments:
7. Have you ever used crutches, a walker, or a cane? q Yes q No Comments:
8. Have you ever broken any bones? q Yes q No Comments:
9. Have you ever had any impacts, falls, or jolts that you feel may have specifically injured your spine? q Yes q No Comments:
10. Have you served in the military? q Yes q No Comments:

    If yes, what dates did you serve? ______________ Were you involved in combat? q Yes q No
11. During the day, I (please check all that apply) q sit q do desk work q walk q stand q do phone work q do heavy lifting

At Post Riverside v 4403 Northside Parkway, Suite #1101 v Atlanta, Georgia 30327
Phone: 404.233.3386 v Fax: 404.233.3186
www.IntegralChiropractic.com

Sports or Leisure

12. I exercise q Daily q Weekly q Monthly q Not at all

    Please describe your exercise activity:

13. Do you play musical instruments? q Yes q No

14. Other hobbies:

Automobile Accidents:

15. Have you been involved in a vehicular collision or near collision (even as a passenger when you didn't think you were hurt)?

	Approximate dates of accidents	Severity (mild, moderate, or extreme)
Automobile:		
Bus, bicycle, motorcycle/moped, train, airplane, or other vehicles:		

Medical Treatment:

16. Have you ever been hospitalized? q Yes q No If yes, why?

17. Have you had surgery?

18. Have you had: q spinal brace q heel lift q physiotherapy q neck collar q acupuncture q traction q spinal injections q chemotherapy q corrective shoes or bars on shoes q body part in a cast or immobilized

Chemical History

19. What medications are you taking now? (please list prescription and over-the-counter drugs)

Medication	Reason	When started	Dosage per day	Cost

20. What vitamins/minerals/supplements are you taking now? (please list)

Brand or Other Name (Manufacturer)	Reason	When started	Dosage per day	Cost

21. Have you ever worked with any chemical, fume, dust, powder, or smoke for prolonged periods? q Yes q No

22. Please rate your dietary selections using the following scale:

    0 – Do not consume this
    W – Consume this weekly
    M – Consume this monthly
    D – Consume this daily

_____ Alcohol _____ Artificial sweeteners _____ Eggs _____ Diet food

_____ Coffee _____ Cooked, canned vegetables _____ Poultry _____ Organic foods

_____ Tobacco _____ Raw vegetables _____ Fish _____ Dairy (milk products)

_____ Fruit _____ Beef _____ Seafood _____ Fasting/Detox

_____ Whole grains _____ Diet soda _____ Refined sugar

23. The type of diet I usually follow is classified as:

Emotional History

24. How would you rate your physical health? (please circle the most appropriate answer for you)

Poor									Great
1	2	3	4	5	6	7	8	9	10

25. How would you rate your emotional/mental health? (please circle the most appropriate answer for you)

Poor									Great
1	2	3	4	5	6	7	8	9	10

26. What do you do for stress relief?

27. What is your spiritual affiliation?

28. Does your immediate family receive chiropractic adjustments?

29. What do you hope to receive from chiropractic care in this office?

30. What else would you like to share about yourself so that we may better understand why you have chosen to see the chiropractor in this office?

The above information is accurate to the best of my knowledge.

Signed: ______________________________ Date: ______________________

Insurance Release

I hereby instruct and direct my insurance company ______________________ to pay Integral Chiropractic Center for services rendered at this office and give direct assignment of benefits for payment to Integral Chiropractic Center.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Integral Chiropractic Center may prepare any necessary reports and forms to assist me in making the collection from the insurance company and that the amount authorized to be paid directly to Integral Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at Integral Chiropractic Center, any fees for professional services rendered me will be immediately due and payable.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signed: ______________________________ Date: ______________________