File#_____

527 Mills Ave. Ste 201A, Greenville, SC 29605; Phone 864-603-1450

Name:_____ Date:_____

Address:_____City:_____State:____Zip:_____

Home Ph:_____Work Ph:_____Cell Ph:_____

Best Number to contact you: Home Work Cell Social Security #:_____

Email Address:_____ **Cell Provider: Text (circle) Yes No**

Birth date:_____ Age:_____ Sex: M F circle one: single married widowed divorced separated

Occupation:_____ Spouse's occupation:_____

Spouse's Name:_____ Name and Ages of Children:_____

Whom may we thank for referring you or how did you hear about us? (Circle all that apply)

TV	Google	Website
Radio	Massage Day at work	Facebook
Person_____	Print advertisement_____	Other_____

Would you like us to check your insurance benefits to see if they will contribute to your care? ___Yes ___No

Main reason for consulting our office today:_____

Anything about your Nerve System and Spine we should know about?_____
_____

What is your level of commitment to yourself, your life and well-being? ___High ___Medium ___Low

Have you ever sought the services for this or any other health concern from the following:
___Massage therapist ___Acupuncturist ___Naturopath ___Yoga Studio ___Physical Therapist
___Personal Trainer ___Nutritionalist ___Rolfer ___Pilates ___Other_____

Who is your primary care doctor?_____Phone #_____

Have you been adjusted by a chiropractor before? ____Yes ____No
Who:_____ Date of last Adjustment:_____
Frequency of visits: _____times a week/month Duration of care: _____weeks/months/yrs

- What is your daily fluid intake: Coffee____/day Alcohol____/day Water____/day Soda____/day
- Sleep/Rest Habits: Daytime naps: Y N Hours a night:_____/hrs Do you wake up refreshed? Y N
- Exercise Habits: (please describe what you do and how often)_____
  _____
- What type of work do you do?_____ Satisfied/Enjoy your work? Y N
- Do you use prescription, over the counter and/or recreational drugs/medications? Y N (If yes, please list)

- What are your current play and relaxation activities_____
  _____

Check any of the symptoms or conditions below that you experience? **File#_____**

___Headaches	___Carpal Tunnel	___Asthma	___Digestive Problems
___Neck Pain	___Problem Sleeping	___Vertigo	___Pain Between Shoulder Blades
___Mid-Back Pain	___Ringing in Ears	___Anxiety	___Shortness of Breath
___Low-Back Pain	___Loss of Balance	___Cancer	___Tension across Top of Shoulders
___Sciatic Pain	___High Blood Pressure	___ Allergies	___ Numbness in Arms/Legs
___Leg or Hip Pain	___Weight Trouble	___Dizziness	___ Menstrual Pain
___Shoulder/Arm Pain	___Low Energy/Fatigued	___Depression	___Other_____

If Female, are you pregnant or any chance of being pregnant? ___Yes ___No

Which one of the above symptoms is worst?_____ How long have you had it?_____

When it is at its worst, how does it feel?_____

The following 3 areas can contribute to nerve interference and diminished quality of life. Circle the areas that apply to you and when.

C=Child T=Teenager A=Adult N=Not at all (please circle)

Physical Stress		**Emotional Stress**		**Chemical Stress**	
Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip/ fall	C T A N	Career	C T A N	Smoker	C T A N
Car Accident	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Sports Injury	C T A N	Money	C T A N	Caffeine	C T A N
Physical Abuse	C T A N	Fast paced life	C T A N	Artificial Sweeteners	C T A N
Work Injury	C T A N	Hold in Feelings	C T A N	Prescription Drugs	C T A N
Poor Posture	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on wallet	C T A N	Perfectionist	C T A N	Self Medicate	C T A N
Stomach sleeper	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Computer work	C T A N	Loss of loved one	C T A N		
Repetitive lift/bending	C T A N				
Prolonged Driving	C T A N				
Prolonged Standing	C T A N				
Prolonged Sitting	C T A N				
Surgery/Broken bones	C T A N				
Lack of Physical Activity	C T A N				
Excess Physical Activity	C T A N				

- What do you feel is the primary stress in your life?

- Rate (circle) your combined overall level of stress from all sources listed above:

No Stress—1—2—3—4—5—6—7—8—9—10--High Stress

TERMS OF SERVICE

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

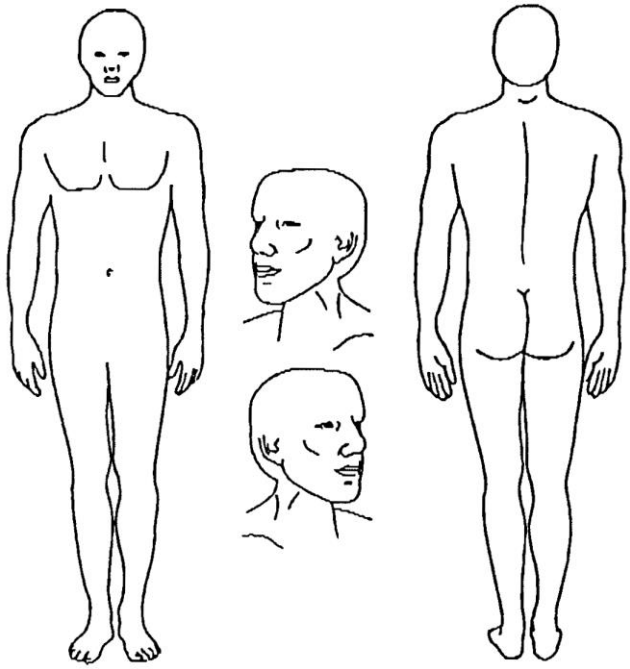
ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.
HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.
Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I,(Printed name)_____ (Signature)_____undertake chiropractic services on the understanding of and agreement with, the above explanation. _____(Date).

Consent to evaluate and adjust a minor and/or child: I, _____ (Print name) being the parent or legal guardian of _____(Print name) give permission for my child to receive chiropractic care.

File #:_____

INITIAL/PROGRESS REPORT



PLEASE MARK YOUR AREAS OF PAIN ON THESE FIGURES, INDICATING WHICH TYPE OF PAIN YOU ARE EXPERIENCING.

A = SHARP PAIN
B = DULL PAIN
C = BURNING PAIN
D = NUMBNESS
E = TINGLING

Please mark the intensity of pain you are experiencing on the pain scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild		Discomforting		Distressing		Horrible		Excruciating	

Daily Activities: Effects of Current Condition on Performance

1. Bending:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
2. Carrying Groceries:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
3. Change Posn–Sit-Stand:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
4. Climb Stairs:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
5. Driving:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
6. Ext Computer Use:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
7. Household Chores:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
8. Kneeling:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
9. Lift Children:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
10. Lifting:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
11. Reading (Concentration):	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
12. Self Care–Bathing:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
13. Self Care–Dressing:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
14. Self Care–Shaving:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
15. Sexual Activities:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
16. Sleep:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
17. Sitting:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
18. Standing:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
19. Walking:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
20. Yard Work:	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
21. Other_____	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform
22. Other_____	□ No Effect	□ Mild Painful (Can do)	□ Mod Painful (Limited)	□ Sev Unable to Perform

Date:_____ Name (Printed) _____ Signature _____

Initial Health History

Name:_____ Date_____ File # _____

- What symptoms are causing you to seek care in our office and where is it located?

- Please list any health concerns in your Family History.

- Past Health History (general health, illness, injuries, hospitalizations, medications, surgeries).

- Mechanism of trauma/injury (how did you hurt yourself)? When was the onset of symptoms?

- How would you describe your symptom/problem? Does it radiate?

- Duration (how long), intensity (scale of 1-10 how bad), frequency (how often)

- What makes it better or worse?

- What prior interventions, treatments, or medications have you used for this problem?

- Is there any reason you should not be adjusted?