PATIENT INFORMATION

Date:_____

Patient Name:_____
Full Legal Name (First Middle Last)

Prefer to be called:_____

If patient is a minor, please list parent names:

_____ _____
Mother (Legal Guardian) Father (Legal Guardian)

Address: _____

City: _____ State: ____ Zip: _____

Email: _____

Sex: ❍ M ❍ F Age: _____ DOB: ___/___/___

❍ Single ❍ Married ❍ Widowed ❍ Minor
❍ Separated ❍ Divorced ❍ Partnered for ____ years

Occupation: _____

Employer / School: _____

Spouse's Name: _____

Spouse's Birth Date: ___/___/___

Whom may we thank for referring you:

_____

PHONE NUMBERS

Home Cell
Phone: (___) _____ Phone: (___) _____

Employer / School Phone: (___) _____

IN CASE OF EMERGENCY, CONTACT

Name: _____

Home Cell
Phone: (___) _____ Phone: (___) _____

In case we need to reach you, may we leave a message on your: ❍ Home ❍ Cell ❍ Work ❍ Email

INSURANCE / PAYMENT INFORMATION

Person Responsible for Account: _____

Relationship to Patient: _____

Insurance Carrier:_____

ID Number: _____

Group #: _____ Additional Insurance? Yes No

I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Dr. Witt all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Dr. Witt may use my health care information and disclose such information to the above mentioned insurance company for purpose of obtaining payment for services and determining insurance benefits.

I understand that all services rendered to me are my responsibility and that payment at time of service is expected.

_____ _____
Date Signature

PERMISSION TO TREAT MINOR

I hereby authorize this office and its doctors to administer care to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees and that are charged by this office. I authorize ongoing treatment

❍ Only when I am present ❍ Only if I am notified first
❍ At my child's discretion ❍ For ____ treatments

Signature: Date: / /

ACCIDENT INFORMATION

Is your condition the result of an accident? ❍ Yes ❍ No
If yes, when did accident occur? Date: ____/____/____
Where did it occur? ❍ Auto ❍ Work ❍ Home ❍ Other
If other, please explain: _____

_____

To whom have you made a report of your accident?
❍ Auto Insurance ❍ Employer ❍ Work Comp ❍ Other

Name(s) & Phone Number (if applicable):
_____(___)_____

PATIENT CONDITION

Reason for visit:_____

When did symptoms first appear _____

What do you think the cause is _____

Is this condition the ❍ Same ❍ Better ❍ Worse ❍ Unknown since it started?

Rate your pain on scale of 0 (no pain) 10 (worst imaginable pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: ❍ Sharp ❍ Dull ❍ Throbbing ❍ Numbness ❍ Aching ❍ Shooting
❍ Burning ❍ Tingling ❍ Cramping ❍ Stiffness ❍ Swelling ❍ Other

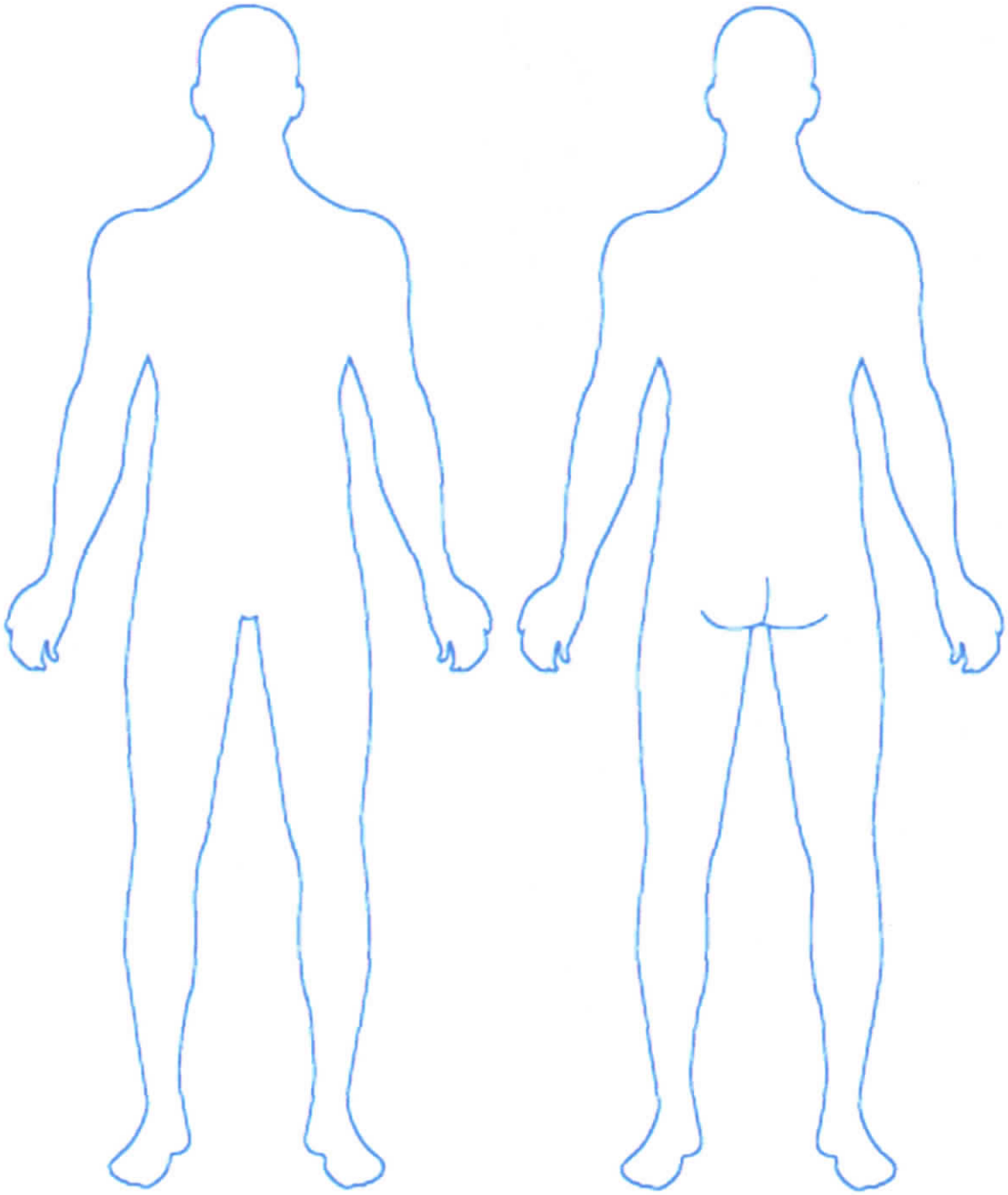
How often do you have this pain? _____

Is the pain ❍ constant or does it ❍ come and go?

Does the pain interfere with your ❍ Work ❍ Sleep ❍ Daily Routine ❍ Recreation ❍ Other: _____

AREA(S) OF PAIN

D = Dull B = Burning T = Tingling S = Sharp A = Achy



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TREATMENT OF CONDITION

What treatment have you already received for your condition? ❍ None ❍ Surgery ❍ Medication ❍ Chiropractic Care ❍ Physical Therapy ❍ Other _____

Please list the names of the Doctor(s) who have already treated your condition _____

_____

_____

REVIEW OF SYMPTOMS

Please check "NOW" for all conditions you are now experiencing and "PAST" for any condition you have experienced during your life

GENERAL	Now	Past
Fatigue	❍	❍
Fever	❍	❍
Night Sweats	❍	❍
Weight Loss	❍	❍
Weight Gain	❍	❍
Headaches	❍	❍
Head Trauma	❍	❍
Dizziness	❍	❍
Change in Vision	❍	❍
Glasses / Contacts	❍	❍
Redness of Eyes	❍	❍
Watering of Eyes	❍	❍
Hard of Hearing	❍	❍
Ringing in Ears	❍	❍
Earaches	❍	❍
Ear Infections	❍	❍
Nose Bleeds	❍	❍
Sinus Congestion	❍	❍
Stiff Neck	❍	❍
Bleeding Gums	❍	❍
Canker Sores	❍	❍
Cold Sores	❍	❍
Mercury Fillings	❍	❍
Sore Throat	❍	❍
Tonsils Removed	❍	❍
Trouble Swallowing	❍	❍
Breast Lumps	❍	❍
Breast Pain	❍	❍
Persistent Cough	❍	❍
Shortness of Breath	❍	❍
Asthma	❍	❍
Emphysema	❍	❍
Bronchitis	❍	❍
Heart Palpitations	❍	❍
Chest Pain	❍	❍
Cold Feet / Hands	❍	❍
Swelling in Ankles	❍	❍
Swelling in Hands	❍	❍
Calf Pain	❍	❍
Varicose Veins	❍	❍

	Now	Past
Blood Clots	❍	❍
Low Blood Pressure	❍	❍
High Blood Pressure	❍	❍
High Cholesterol	❍	❍
High Triglycerides	❍	❍
Anemia	❍	❍
Abdominal Pain	❍	❍
Vomiting / Nausea	❍	❍
Constipation	❍	❍
Diarrhea	❍	❍
Bloating	❍	❍
Belching	❍	❍
Indigestion	❍	❍
Gas	❍	❍
Hemorrhoids	❍	❍
Black Stools	❍	❍
Ulcers	❍	❍
Gall Bladder Disease	❍	❍
Liver Disease	❍	❍
Incontinence	❍	❍
Painful Urination	❍	❍
Urinary Dribbling	❍	❍
Increased Urination	❍	❍
Decreased Urination	❍	❍
Kidney Stones	❍	❍
Urinary Infection	❍	❍
Genital Infection	❍	❍
Impotency	❍	❍
Prostrate Problems	❍	❍
Seizures	❍	❍
Stroke(s)	❍	❍
Loss of Sensation	❍	❍
Poor Coordination	❍	❍
Memory Loss	❍	❍
Hand Trembling	❍	❍
Paralysis	❍	❍
Insomnia	❍	❍
Nervousness	❍	❍
Change in Appetite	❍	❍
Heat Intolerance	❍	❍

	Now	Past
Cold Intolerance	❍	❍
Highly Emotional	❍	❍
Irritable / Restless	❍	❍
Crave Salt	❍	❍
Hyperventilation	❍	❍
Depression	❍	❍
Alcoholism	❍	❍
Drug Addiction	❍	❍
Suicidal Thoughts	❍	❍
Suicide Attempt	❍	❍
Extreme Worry	❍	❍
Sexual Problems	❍	❍
Muscle Pain	❍	❍
Muscle Weakness	❍	❍
Muscle Cramps	❍	❍
Joint Pain	❍	❍
Herniated Disc	❍	❍
Fractures	❍	❍
Dislocations	❍	❍
Ligament Trauma	❍	❍
Arthritis	❍	❍
Osteoporosis	❍	❍
FEMALES ONLY		
Vaginal Itching	❍	❍
Vaginal Discharge	❍	❍
Painful Intercourse	❍	❍
Irregular Periods	❍	❍
Menstrual Cramps	❍	❍
Hot Flashes	❍	❍
Hysterectomy	❍	❍
Ovaries Removed	❍	❍
Are you Pregnant?	❍	_____ Due Date
Contraceptive Type	_____	
Age of First Period	_____	
Duration of Cycle	_____ Between 28-45 days	
Duration of Flow	_____ Between 1-7 days	
# of Pregnancies	_____	
Number of Births	_____	
Number of Miscarriages	_____	

Number of Abortions _____
Last Period _____
Last Pap Smear _____
Last Mammogram _____

ILLNESSES	Now	Past
AIDS / HIV	❍	❍
Anorexia	❍	❍
Bladder Trouble	❍	❍
Bulimia	❍	❍
Cancer	❍	❍
Diabetes	❍	❍
Gout	❍	❍
Heart Disease	❍	❍
Hepatitis	❍	❍
Herpes	❍	❍
Kidney Disease	❍	❍
Leukemia	❍	❍
Mononucleosis	❍	❍
Multiple Sclerosis	❍	❍
Pacemaker	❍	❍
Parasites	❍	❍
Parkinson's Disease	❍	❍
Rheumatoid Arthritis	❍	❍
Stroke	❍	❍
Thyroid Problems	❍	❍
Tuberculosis	❍	❍
Tumors / Growths	❍	❍
Venereal Disease	❍	❍
Yeast Infection(s)	❍	❍
Other _____		

CHILDHOOD DISEASES		
Birth Defects	❍	❍
Chicken Pox	❍	❍
Measles	❍	❍
Mumps	❍	❍
Polio	❍	❍
Rheumatic Fever	❍	❍
Rubella		
Scarlet Fever	❍	❍

HISTORY OF INJURIES / SURGERIES

Approximate Date(s) and Description

Car Accidents _____

Surgeries _____

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Other Injuries _____

Please list the location(s) of **ALL** tattoos and piercings on your body _____

MEDICATIONS

List all medications and why you are taking them.

VITAMINS / HERBS

List all vitamins / supplements and why you are taking them.

ALLERGIES

List all allergies to medications, pollen, foods, etc.

SOCIAL HISTORY

Do you drink alcoholic beverages? ❍ Never ❍ Rarely ❍ Weekly ❍ Daily How many per week? _____

Do you drink coffee? ❍ Never ❍ Occasionally ❍ Often If so, how many cups per week? _____

Do you smoke cigarettes? ❍ Never ❍ Occasionally ❍ Often Number of packs per day _____ for _____ years

Do you have stress? ❍ Yes ❍ No Rate your stress on scale of 0 to 10 _____ Reason _____

Hours you sleep at night? ____ What time do you usually go to bed? ____ Describe sleep problems, if any _____

Are you sexually active? ❍ Yes ❍ No With multiple partners? ❍ Yes ❍ No _____

Have you ever had any sexually transmitted disease(s)? ❍ Yes ❍ No If so, please list _____

DIET & EXERCISE

Exercise	❍ Never	❍ Light	❍ Moderate	❍ Heavy	Hours Per Week: _____		Type: _____	
Physical Work	❍ Never	❍ Light	❍ Moderate	❍ Heavy	Hours Per Day: _____		Type: _____	
Mental Work	❍ Never	❍ Light	❍ Moderate	❍ Heavy	Hours Per Day: _____		Type: _____	
I eat fast food	❍ Never	❍ Daily	❍ Weekly	❍ Monthly	I consume dairy	❍ Never ❍ Daily	❍ Weekly	❍ Monthly
I drink soda	❍ Never	❍ Daily	❍ Weekly	❍ Monthly	I eat vegetables	❍ Never ❍ Daily	❍ Weekly	❍ Monthly
I eat fruit	❍ Never	❍ Daily	❍ Weekly	❍ Monthly	I eat raw seeds / nuts	❍ Never ❍ Daily	❍ Weekly	❍ Monthly
I eat fish	❍ Never	❍ Daily	❍ Weekly	❍ Monthly	I eat food with sugar	❍ Never ❍ Daily	❍ Weekly	❍ Monthly

List the three worst foods you eat during an average week: _____, _____, _____

List the three healthiest foods you eat during an average week: _____, _____, _____

GOALS & LIMITATIONS

What are the goals you would like to achieve being treated in the office? _____

What limitations do you have, if any, in working with the Doctors in this office in achieving optimal health (i.e. Unwilling to take nutritional supplements or herbs, won't give up smoking or alcohol, etc.)? _____

INFORMED CONSENT

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physical therapy, exercises and nutritional supplementation may also be used as part of the treatment. During the manipulation/adjustment the doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you experience when you "crack" your knuckles. You may feel or sense movement.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware, as with any health care procedure, there are certain complications which may arise during a chiropractic manipulation/adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain and myelopathy. Some patients may feel some stiffness and soreness following the first few days of treatment.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with the one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may susceptible to that kind of injury. The other complications are also generally described as "rare."

There are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. The practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

Other treatment options for your condition include self administered, over-the-counter analgesics, medical care with prescription drugs, naturopathic remedies including homeopathy, herbs, vitamins and minerals, home exercises and stretches and dietary changes.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____	_____	_____
Signature of Patient	Printed Name	Date
_____	_____	_____
Signature of Parent or Guardian (if a minor)	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date