IMAGO DEI CHIROPRACTIC & FAMILY WELLNESS

Welcome!
Please tell us a little about yourself:

Name _____ Today's Date_____
Birthdate _____ Age_____ Sex ❑ M ❑ F
Address _____
City_____ State_____ Zip _____
Preferred Phone _____ ❑ Cell ❑ Home ❑ Work
Spouse/Significant Other's Name _____
Kid's Names and Ages _____
Your Employer _____
Type of Work_____
E-Mail Address _____
Have you been to a chiropractor before? ❑ No ❑ Yes
Emergency Contact _____ Relationship_____
Ph # _____
Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Imago Dei Chiropractic and Family Wellness to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:
  ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ Date_____

Patient / Parent Signature

(This represents a long-term authorization for all occasions of service)

289 E. Ellendale Ste 701 Dallas, OR 97338

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What brings you to our office?

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

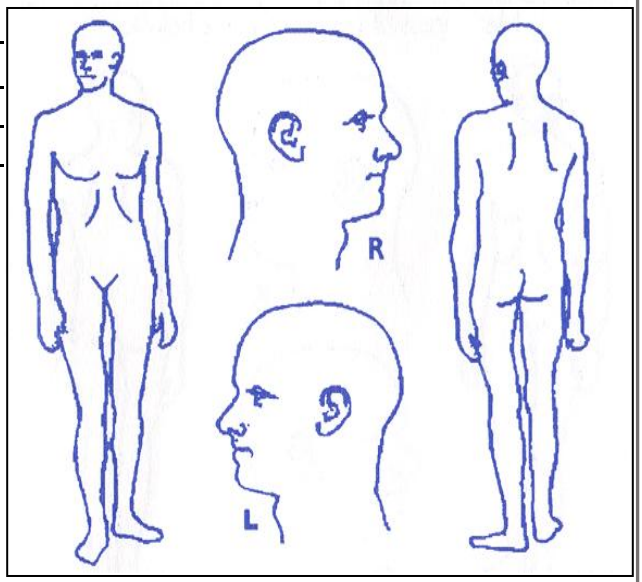
2. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

3. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

4. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
5. What makes it better? _____
6. What makes it worse? _____
7. What Doctor(s) have you seen for this? _____
_____
8. Type of treatment: _____
9. Results: _____
10. For female patients: Are you pregnant? ❑ No ❑ Yes

NOTES: _____
_____
_____
_____

Please mark all areas of concern:



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GENERAL HEALTH HISTORY

Patient Name_____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other			

Please list any medications you are taking:

_____

_____

_____

PAST HISTORY

1. List any past auto collisions:_____ **Was any care received?**_____

2. List any past work injuries: _____ **Was any care received?**_____

3. List any past sport, recreational, or home injuries_____

4. Please describe any past conditions and treatment received: _____

_____

5. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

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