1210 6th St. Ste. #103

Nevada, Iowa 50201

ABOUT YOU.

Name ____ Today's Date__________________________

Birthdate ____________ Age________Address ____

City __________________________ State ______ Zip ___________Home Phone ____________________

Cell Phone ___________________ Work Phone ____________ Gender M F

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_______________________________________ 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 The Connect Chiropractic 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.

____

Patient / Parent Signature (This represents a long term authorization for all occasions of service)

REASON FOR SEEKING CARE.

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. ____ **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__________________

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better?____

7. What makes it worse? ____

8. What Doctor's have you seen for this?__________________________________
____

9. Type of treatment:____

10. Results: ____

NOTES:

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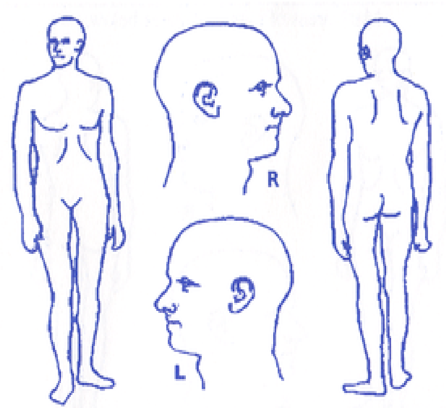
Please mark all areas of concern.



Are you pregnant? Yes No