

Welcome To Imagine Wellness Chiropractic Center

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age ____ Today's date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home # () _____ Work # () _____ Ext. _____ Soc. Sec. # _____ - _____ - _____
 Fax # () _____ Cell # () _____ E-mail Address _____
 Male Female # of Children _____ Single Married Significant Other Widowed Separated Divorced
 Your occupation _____ Work duties _____ **WOMEN ONLY: Are you pregnant? No** _____ **Yes** _____
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
 Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash* *Check* *CC* *GC*
 Which doctor are you scheduled to see today? Dr. Roxane Zamora Dr. Joesph Schiegg
 Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

INSURANCE INFORMATION: Name of Insurance Company _____ Policy/Group Number _____
 Your Deductible Amount? _____ Co-Pay Amount? _____ Has Your Deductible Been Met This Year? _____
 Is this injury related to an auto accident? _____ If yes name of your : Auto Insurance Co _____ Polic# _____ Claim# _____
 Agents Name _____ Phone number _____ Do you have met pay? _____ Is this injury work related? _____ Have you reported it? _____

Your Health Profile

***FOR PRESENT CONDITIONS MARK "X", PAST CONDITIONS MARK "P" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)

<input type="checkbox"/> Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both	<input type="checkbox"/> Hip Pain R / L	<input type="checkbox"/> Neck Stiffness/ Pain	<input type="checkbox"/> Back Stiffness/Pain
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Colds / Flu	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Asthma/Emphysema
<input type="checkbox"/> Swollen Painful Joints	<input type="checkbox"/> Tremors	<input type="checkbox"/> Blurred Vision R / L	<input type="checkbox"/> Double Vision R / L
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Pain w/ Cough / Sneeze	<input type="checkbox"/> Stroke	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Buzzing/Ringing in ears	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Nervousness/Anxiety
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability/Mood Swings	<input type="checkbox"/> Tension/Stress
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Recurring Infection	<input type="checkbox"/> Diarrhea/Constip./Gas
<input type="checkbox"/> Cold feet	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Jaw/TMJ Problems
<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Problems Urinating	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> PMS	<input type="checkbox"/> Meopause	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer
<input type="checkbox"/> Other			

(Type) _____
 Additional Explanation: _____

Current Health Condition

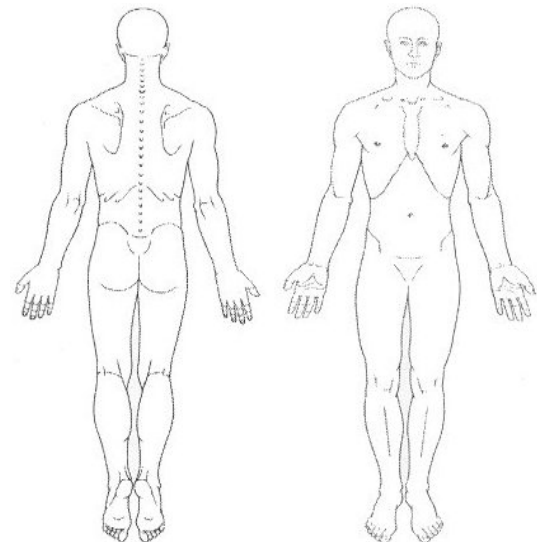
Chief Complaint (why you are here today): _____
 When did this condition begin? _____ Has it ever occurred before: Yes No
 If due to injury or accident please explain _____

Severity: On a scale from 1(mild pain) – 10(disabling pain) _____
 Does this pain travel or radiate? If so,
 Where? _____

Quality: (mark all that apply)
 Burning Diffuse Dull/Aching Localized
 Sharp Shooting Stabbing Tingling
 Radiating Other _____

What makes this better? _____
 What makes this worse? _____

Please mark on the diagram below the area of discomfort. ↓



Is there a family history of any of the following conditions? (Indicate family member including, parents, grandparents, & siblings)

Heart Disease _____ Diabetes _____ Cancer _____ Arthritis _____ Other _____

Timing:

Worse AM Worse PM Worse W/ Activity Worse Sleeping
 Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

- | | | | |
|-----------------------|--|---|--|
| Changing Positions | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sit to Stand | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing Stairs | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Computer Use | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Household Chores | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting/Bending | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Reading/Concentration | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Carrying | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dressing/Shaving | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Playing Sports | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Standing | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard Work | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking/Running | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Please List any effects that this may have on any Work Related/Recreational Activities: _____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions? _____

Is there anything else you think the doctor should know concerning your condition? Yes___ No ___

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

_____/_____/_____
Signature

Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able 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 of correction 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 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 the 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.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

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