

# Welcome To Imagine Wellness Chiropractic Center

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Work# ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_ 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

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? \_\_\_\_\_ Date of accident? \_\_\_\_\_ If yes name of your auto Insurance Co \_\_\_\_\_ 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)<br>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"/> Menopause                | <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? \_\_\_\_\_

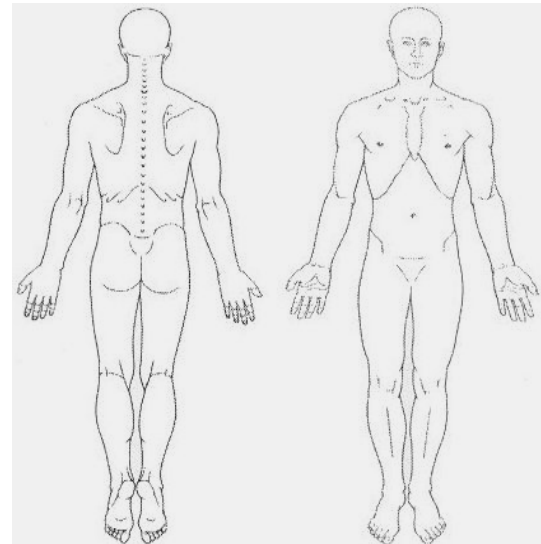
**Quality:** (mark all that apply)

- |                                    |                                      |                                      |                                    |
|------------------------------------|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Burning   | <input type="checkbox"/> Diffuse     | <input type="checkbox"/> Dull/Aching | <input type="checkbox"/> Localized |
| <input type="checkbox"/> Sharp     | <input type="checkbox"/> Shooting    | <input type="checkbox"/> Stabbing    | <input type="checkbox"/> Tingling  |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Other _____ |                                      |                                    |

What makes this better? \_\_\_\_\_

What makes this worse? \_\_\_\_\_

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



**Family History**

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 or Recreational Activities: \_\_\_\_\_

Are there any other conditions that the doctor should address? If so, list and describe: \_\_\_\_\_

**Medications:** What medications are you currently taking and for what conditions? \_\_\_\_\_

On this scale mark where your health is **Optimal Health** (feeling healthy) 1 2 3 4 5 6 7 8 9 10 (feeling unhealthy) **Degenerating Health**

How would good health help you live a more fulfilling life? (Example: have energy to play with children/ grandchildren, improved golf game/sports ability, more focused, improved quality of life, increased stamina)

*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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