



### Patient Information

Name:	Today's Date:	
What you prefer to be called:		
Mailing Address	City/State:	Zip:
Home Phone: (    )	Work Phone: (    )	Cell: (    )
E-mail Address <i>(for newsletters and appointment information)</i> :		
Birth Date:	Age:	Social Security #:
How did you learn about our office?		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Spouse's Name:		
Name and Ages of Children:		
Patient's Employer/Business:		
Occupation:		
Recent Work-Related Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous Chiropractic Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Approximate Last Visit Date:	

***Please check reasons for pursuing chiropractic care:***

- I'm continuing ongoing care from another chiropractor.
- I'm interested in wellness and natural health care.
- I'm concerned about my health and I'm looking for answers.
- I have a specific condition that concerns me.

Explain condition or symptom:

---

---

---

---

- I want to improve my immune function.
- I have no idea why I'm here. Please take the time to explain to me what you offer.

***In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:***

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Sleep Problems      | <input type="checkbox"/> Menstrual Problems  | <input type="checkbox"/> Weight Problems        |
| <input type="checkbox"/> Postural Imbalance  | <input type="checkbox"/> Gas/Bloating  | <input type="checkbox"/> Dizziness/Fainting  | <input type="checkbox"/> Ringing in Ears     | <input type="checkbox"/> Allergy/Sinus Problems |
| <input type="checkbox"/> Bladder Trouble     | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Frequent Colds      | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Short leg/Orthotics | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Menopausal Symptoms    |

***Check the following conditions that YOU have had. mark the Circle for conditions that are common to FAMILY MEMBERS.***

- |  |                                       |                                    |                                   |                                   |   |
|--|---------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> AIDS          | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hyper/Hypothyroidism |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Ulcers   | <input type="checkbox"/> Multiple Sclerosis   |

***If you take prescription medications, please let us know the conditions for which you take the medication. (We do not need to know the name of the medication at this time.)***

---

---

---

***THE STRESS TEST:***

***The following areas of stress can cause mis-aligned vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?***

***Physical/Emotional/Chemical Stress:***

- |  |  |
|--|--|
| <input type="checkbox"/> Birth Trauma                                | <input type="checkbox"/> Slips/Falls                       |
| <input type="checkbox"/> Car Accidents                               | <input type="checkbox"/> Sports Injuries                   |
| <input type="checkbox"/> Physical Abuse                              | <input type="checkbox"/> Poor Posture                      |
| <input type="checkbox"/> Work Injuries                               | <input type="checkbox"/> Sitting on a Wallet               |
| <input type="checkbox"/> Sleeping on Stomach                         | <input type="checkbox"/> Extensive Computer Work           |
| <input type="checkbox"/> Carrying Heavy Purse/Backpack/Child         | <input type="checkbox"/> Repetitive Lifting/Bending        |
| <input type="checkbox"/> Driving for Many Hours                      | <input type="checkbox"/> Continuous Hours Sitting/Standing |
| <input type="checkbox"/> Children Stress                             | <input type="checkbox"/> Career Stress                     |
| <input type="checkbox"/> Relationship Stress                         | <input type="checkbox"/> Concealed Feelings                |
| <input type="checkbox"/> Quick Tempered                              | <input type="checkbox"/> Smoker/Second Hand Smoke          |
| <input type="checkbox"/> Poor Diet/Excessive Sugar                   | <input type="checkbox"/> Caffeine                          |
| <input type="checkbox"/> Artificial Sweeteners                       | <input type="checkbox"/> Prescription Drugs                |
| <input type="checkbox"/> Over-the-Counter Drugs (ex. Tylenol/Motrin) |  |

**Notice:**

It is important that our patients and we have the same health objectives regarding chiropractic care. Regardless of **what a disease or condition is called, we do not offer to treat it.** Our only practice objective is to eliminate a major interference to the expression of the body's innate and internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe the greatest Doctor is the one already inside each of our patients, and we only help to maximize their inherent healing power without the use of drugs or surgery.

**Disclosures:**

- Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Generations Chiropractic does not accept assignment of insurance benefits, but will provide all documentation for me to use in filing claims with my insurance company.
- If my case is accepted by Generations Chiropractic, adjustments will be performed in our adjusting area, where others may be receiving adjustments. I understand and consent to this form of care.
- I consent to have my spouse/significant other present during my report of findings.

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Date*

**Please provide a signature for any of the following that apply to you:**

**Pregnancy Release (Females of Child-Bearing Age):**

I certify that to the best of my knowledge I am not pregnant, and Dr's Denny and Mandy Warren and their associates have my permission to perform an x-ray evaluation. I have been advised that x-rays could be hazardous to an unborn child.

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Date*

**Medicare Patients:**

**Patient's or Authorized Person's Signature** - I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits to myself or to the party who accepts assignment below. I am aware that Medicare may deny the claim for care and I agree to pay for services not covered my Medicare.

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Date*