WELCOME TO GARDEN STATE FAMILY CHIROPRACTIC

Thank you for choosing our office. Our goals are first to address the issues that brought you to this office, and second, to maximize your overall health potential by correcting Vertebral Subluxations in your spine, allowing your body to function at it's best.

PATIENT INFORMATION

Print Full Name: _____ Name you go by:_____ Today's Date: _____
Street Address: _____ City: _____ State: _____ Zip:_____
Age: ____ Date of Birth: _____ Social Security #: _____ E-mail: _____
Height: _____ Weight: _____ Please Check (✓): Married□ Single□ Other□ # of children:_____ ages: _____
Employer: _____ Street Address: _____ City: _____
State: _____ Zip: _____ Driver's License #: _____ State: _____
Where did you hear about our office or who referred you? _____

PHONE NUMBERS

Home: _____ Work: _____ ext._____ Cell: _____
Preferred phone number: Home / Work / Cell Best number to contact you/leave a message: _____
In case of emergency, notify: _____ Relationship: _____ Phone: _____

INSURANCE

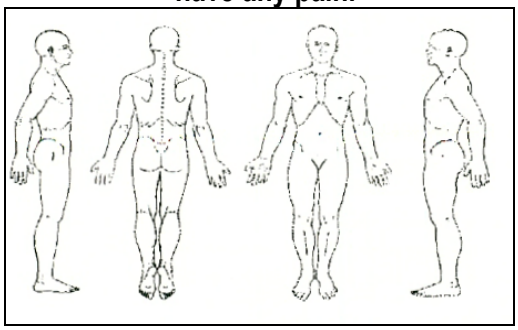
Do you have medical insurance? Yes□ No□ Insurance Company Name: _____
Insured's Name (if different from patient): _____ Relationship to patient: _____
Insured's Date of Birth: _____

CHIEF COMPLAINT

If you are here for wellness services, please check □; otherwise please briefly describe the reason for seeking chiropractic care: _____
Is this due to an accident or injury? Yes□ No□ Date: _____ Type of accident: Auto□ Home□ Other□_____

Is your condition getting worse? Yes□ No□ Does it interfere with your: Work□ Sleep□ Daily routine□ Exercise□
On a pain scale of 10 being worst pain possible/required bedrest and 1 being mild pain, where would you rate your pain right now? _____ When it first happened? _____
How long have you had the above complaint(s)? _____

Place an "X" on the diagram where you have any pain.



How often do you have the above complaint(s)?_____
What makes it worse? _____
What makes it better?_____

Check all that apply:
constant□ comes & goes□ stays in one area□ moves around□
sharp□ dull/ache□ throbbing□ stabbing□
numbness/tingling□ burning□ other□_____
worse in the morning□ worse in the evening□
worse after a specific activity□ what one?_____
Are you under the care of any other doctor for this problem? Yes□ No□
Name of Doctor: _____

What made you to decide to visit a chiropractor? (recent aggravation, tired of the pain, someone convinced me, wanted to try something different, it has helped in the past, want wellness care, etc.): _____

FEMALES ONLY

Is it possible that you are pregnant? Yes□ No□ If yes, due date: _____ Are you on Birth Control Pills? Yes□ No□

The vast majority of our patients have experienced dozens of falls and repetitive motions over the course of their lifetime. Please tell us about your lifestyle now and in the past:

Medications you now take: Advil / Ibuprofen□ High Blood Pressure□ Painkillers□ Muscle Relaxers□ Allergy□
Anti-Depressants□ Cold Medications□ Hormone Replacement□ Others:□(specify)_____
Please list any past surgeries/hospitalizations and dates: _____
Were you sick frequently as a child? _____ Do you get sick often now? _____
Exercise: None□ 1-2x week□ 3-4x week□ 5-7x week□ Are you a member of a health club or gym? Yes □ No□
What nutritional supplements do you take?_____
Do you smoke? Yes□ No□ If yes, how long? _____ Do you sleep on your stomach? Yes□ No□ Sometimes□
How many car accidents or minor fender benders have you been in? 5+□ 3-4□ 1-2□ None □
Which of the following have you **ever** been involved in? Football□ Basketball□ Soccer□ Running□ Military □
Gymnastics/Cheerleading □ Martial Arts□ Horseback riding□ Other: _____
Have you **ever**: Fallen down (stairs, tree, bike, monkey-bars, roof, etc) □ Slipped/Fell on the ground (or ice) □
Had a sports injury □ Had a stress or strain while working □ Broken a bone □ Which one(s)? _____
Do you … Sit more than 4 hours per day□ Drive more than 2 hours per day□ Perform repetitive tasks (typing/lifting) □

WORK & FAMILY HISTORY

Your Occupation: _____ Work Duties: _____
Spouse's health status: _____ Children's health status: _____
Past or present health problems of parents & siblings: _____

CHIROPRACTIC HISTORY

When did you last see a Chiropractor? _____ Reason for care: _____
What spinal maintenance programs were you given to maximize the future stability of your spine? _____
Did you follow it: Yes□ No□ If not, why? _____
Are other family members under chiropractic care? Yes□ No□ Who? _____

WELLNESS COMMITMENT

To better understand your individual health objectives, please check all that are closest to your personal health goal(s):
Symptom Relief/Temporary Relief□ Restore Health□ Maximum Correction□ Wellness & Prevention□ Improved Performance□

Please check any health issues you are currently experiencing or have had in the past:

Condition or Symptom	Constantly or Frequently	Sometimes or Occasionally
Headaches / Migraines	□	□
Dizziness	□	□
Fainting / Seizures	□	□
Insomnia	□	□
Earaches /Hearing problem	□	□
Neck Pain	□	□
Shoulder/Arm/Hand Pain	□	□
Numbness/Tingling in arms	□	□
Frequent Colds	□	□
Asthma/Difficulty Breathing	□	□
Allergies / Sinus problems	□	□
Upper Back Pain	□	□
Mid Back Pain	□	□
Digestive Problems	□	□
Hip Pain	□	□
Leg/Foot Pain	□	□
Numbness/Tingling in legs	□	□
Low Back Pain /	□	□

Condition or Symptom	Constantly or Frequently	Sometimes or Occasionally
Arthritis / Joint Pain	□	□
Female / Male Problems	□	□
Cancer (past or current)	□	□
Diabetes	□	□
Osteoporosis	□	□
Other _____	□	□

I do hereby authorize Garden State Family Chiropractic to administer such care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature Date