

Welcome to Anatomy Power Chiropractic

Chiropractic Care for a Balanced Life

Date: _____

Patient Information

Patient Name: _____

Address: _____

City: _____

State/Zip: _____

Birthdate: _____

SSN: _____

Occupation: _____

Contact Information

Cell Phone: (____) _____

Home Phone: (____) _____

Email: _____

Family History

Please check any that apply to your family: Cancer
 Seizure Kidney Disease Diabetes Heart
Disease High Blood Pressure Ulcers
 Osteoarthritis Alcoholism Arthritis Other

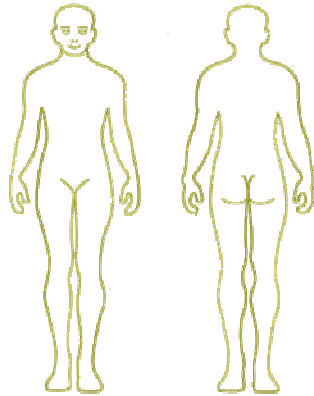
Patient Condition

Reason for visit? _____

When did your symptoms appear? _____

Is this condition
getting worse?
 Yes No

Mark an X on the
picture where you
continue to have
pain, numbness or
tingling.



Rate the severity
of your pain on a scale from 1 (least pain) to 10 (severe
pain) _____

Type of pain: Sharp Dull Throbbing
 Numbness Aching Shooting Burning
 Tingling Stiffness Cramps Swelling
 Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Recreation
 Sleep Daily Routine Other: _____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

Assignment and Release

I certify that I have healthcare insurance with [Company
Name] _____

and assign directly to Anatomy Power all insurance benefits, if
any otherwise payable to me for services rendered. I understand
that I am financially responsible for all charges whether or not
paid by insurance. I authorize the use of my signature on all
insurance submissions. The above named doctor may use my
health care information and may disclose such information to the
above named Insurance Company and their agents for the purpose
of obtaining payment for services and determining insurance
benefits or the benefits payable for related services.

Signature of Patient, Parent or Guardian

Please print name of Patient, Parent or Guardian

Accident Information

Is this condition due to an accident? Yes No

Date of the accident: _____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker's Comp Other:

HEALTH HISTORY

What treatment have you already received for your condition? ___Chiropractic ___Medications ___Surgery ___Physical Therapy

Date of last medical office visits: Physical Exam _____ Medical Doctor Visit _____

- | | | | | |
|----------------------|--------------------|------------------------|-------------------------|-------------------------------------|
| ___Allergy Shots | ___Epilepsy | ___Herniated Disc | ___Neck Pain | ___Stress |
| ___Arthritis | ___Foot/Ankle Pain | ___Herpes | ___Osteoporosis | ___Thyroid Problems |
| ___Asthma | ___Breast Lump | ___High Blood Pressure | ___Pacemaker | ___TMJ |
| ___Athletic Injuries | ___Fracture | ___High Cholesterol | ___Parkinson's Disease | ___Tumors / Growths |
| ___Back Pain | ___Glaucoma | ___Hip Pain | ___Pinched Nerve | ___Work-related Tension |
| ___Breast Lump | ___Gout | ___Kidney Disease | ___Prosthesis | ___Ulcers |
| ___Bronchitis | ___Headaches | ___Knee Pain | ___Rheumatoid Arthritis | ___Whiplash |
| ___Cancer | ___Heart Disease | ___Liver Disease | ___Scoliosis | ___Weight Gain or Loss (Circle one) |
| ___DiscProblems | ___Hepatitis | ___Migraine | ___Sciatica | ___Other: _____ |
| ___Diabetes | ___Hernia | ___Multiple Sclerosis | ___Shoulder Pain | |

EXERCISE	WORK	LIFESTYLE HABITS	
___None	___Sitting	___Smoking	Cigs/Day _____
___1-2 times weekly	___Standing	___Alcohol	Drinks/Week _____
___3-4 times weekly	___Do you travel?	___Coffee/Caffeine Drinks	Cups/Day _____
___5+ times weekly	___Is your job stressful?	___Are you taking vitamins/herbs?	Pills/Day _____

Are you pregnant? ___Yes ___No Due Date: _____

Please describe any that apply to you:

Falls _____ Date _____ Head Injuries _____ Date _____ Broken Bones _____ Date _____
 Disocations _____ Date _____ Surgeries _____ Date _____ Illnesses _____ Date _____

MEDICATIONS	FOODS DAILY	VITAMINS
Condition	Drug Name	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____