



CONFIDENTIAL PATIENT INFORMATION

Health is a process. Welcome to your first step.

Date _____

Patient # _____
(for office use only)

Please fully complete all blank spaces or indicate NA (not applicable). **THANK YOU!**

Patient Name _____
First Middle Last

Address _____
Street City State Zip Code

Birth date _____ Age _____

Single Married Separated Divorced Widow/Widower

Occupation _____ Employer Name _____

Home Phone # _____ Cell # _____ Work # _____

E-Mail Address _____

Spouse Name _____

Names and Ages of Children _____

Emergency Contact _____
Name Address Phone #

Who suggested you see us? _____

Reason for consulting this office? _____

Is your condition due to a:

Work Injury? Yes No Auto Accident? Yes No

Do you have Medicare? Yes No

Payment is expected at the time services are provided. Cash, personal check or credit card (MC, Visa, Discover) are acceptable forms of payment. Your receipt includes all the information necessary for submission to an insurance company. If you have any questions, please feel free to ask.

Signature _____
(If patient is a minor, name of parent, guardian, etc.)

Name: _____

Date: _____

Age: _____ Male Female

YOUR HEALTH PROFILE

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness in the future. On a daily basis we experience physical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability

Your Childhood Years

	Yes	No	Unsure	Comments.
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet? (i.e., crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any traumas (physical or emotional), or broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Adult – (18 to present)

Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Have you been in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Have you had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Have you had any other injuries?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Have you had any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>		_____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints and are here for wellness services, please check (✓) here _____ **“Wish to have Chiropractic Wellness Services”** and skip to “Family Health Conditions” Others need to **briefly describe the chief area of complaint, including the effect it has had on your life.....**

Chief complaint: _____

If you are experiencing pain, is it: Sharp Dull Comes and goes Travels Constant

Does the pain radiate? Yes No Where: _____

Since the problem started, is it: About the same Getting better Getting worse

What makes it worse: _____ What makes it better: _____

How often does it occur: _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

Chiropractor _____

Medical Doctor _____

Other _____

Please check (✓) all symptoms you have ever had even if they do not seem related to your current problem.

- | | | | |
|---------------------------------------------------|---------------------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

List any other health problems or illnesses _____

Health Conditions of:

Children _____

Mother _____

Siblings _____

Father _____

Do you:

Buy bottled water: Yes No

Belong to a health club: Yes No

Consume vitamins or supplements: Yes No

List your current hobbies and leisure activities _____

What is your sleeping position: Stomach Back Left side Right side

On a scale of 1-10 (1=none/10=extreme) describe your stress level:

Occupational _____

Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Print Name _____

Signature _____

Date _____

ZAK CHIROPRACTIC, LLC

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(816) 525-9900

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 used 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 examination, 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 accept chiropractic care on this basis.

(signature)

(date)