CONFIDENTIAL PATIENT INFORMATION

Health is a process. Welcome to your first step.

Patient # __________

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

Date ________________

Patient Name ____
First Middle Last

Address ____
Street City State Zip Code

Birthdate ____________________________ 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 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?	☐	☐	☐	____________________
Did you have any serious falls as a child?	☐	☐	☐	____________________
Did you play youth sports?	☐	☐	☐	____________________
Did you take/use any drugs?	☐	☐	☐	____________________
Did you have any surgery?	☐	☐	☐	____________________
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐	____________________
Were you involved in any car accidents?	☐	☐	☐	____________________
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	____________________
Did you suffer any traumas (physical or emotional), or broken bones?	☐	☐	☐	____________________
Were you vaccinated?	☐	☐	☐	____________________
Were you under regular chiropractic care?	☐	☐	☐	____________________

Adult – (18 to present)	Yes	No	COMMENTS
Do/did you smoke?	☐	☐	____________________
Do/did you drink alcohol?	☐	☐	____________________
Have you been in any car accidents?	☐	☐	____________________
Have you had any broken bones?	☐	☐	____________________
Have you had any other injuries?	☐	☐	____________________
Have you had any surgeries?	☐	☐	____________________
Do/did you play any adult sports?	☐	☐	____________________

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, it is… ☐ 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.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ 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:

______________________________ ______________

Signature Date

ZAK CHIROPRACTIC, LLC

David Zak, D. C.
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Lee's Summit, MO 64063

(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 objectives 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)