

ABOUT THE PATIENT

Elevation Chiropractic, 5300 Highland Dr. STE B, Little Rock, AR, 72223

Name _____ Today's Date _____ Birthdate _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M ☐ F
Significant Other's Name _____ Kids' Names and Ages _____
Your Employer _____ Type of Work _____
e-Mail Address _____ Have you been to a chiropractor before? ☐ No ☐ Yes
Emergency Contact _____ ph # _____
Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Elevation Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

Patient / Parent Signature _____

(This represents a long term authorization for all occasions of service)

Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
2. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
3. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
4. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
6. What makes it better? _____
7. What makes it worse? _____
8. What Doctor(s) have you seen for this? _____

9. Type of treatment: _____

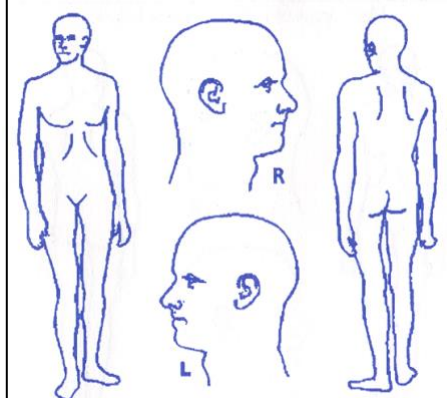
10. Results: _____

NOTES: _____

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Elevation Chiropractic, 5300 Highland Dr. STE B, Little Rock, AR 72223

Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies / Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication Side Effects |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands or Feet cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble Walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg / Foot Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Light Bothers Eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Past Present

- | | | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Thinner use |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | ___High or ___Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke History |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain all Over |
| <input type="checkbox"/> | <input type="checkbox"/> | Tension / Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ☐ No ☐ Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Is there any other family history you want us to know? _____