Boulder Ridge Office Park
125 Slate Dr., Suite 1
Bismarck, ND 58503

Alpha CHIROPRACTIC

701-751-8300
staff@alphachiropracticnd.com
www.alphachiropracticnd.com

Name _____ Birth Date____/____/____ Appt. Date____/____/____

Address _____ Vitals: Height_____Weight_____Blood Pressure _____

City_____State_____Zip_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Cell Phone # _____ Employer_____

Home Phone # _____ Type of work _____

Email Address _____ Work Phone # _____

Emergency Contact _____ Insurance Provider _____

Relationship to you _____ ☐ Deductible ☐ Co-pay ☐ Unsure, please check for me

Employer _____ Have you been adjusted by a chiropractor before?

Phone # _____ ☐ No ☐ Yes; Approximate date of last visit_____

Is today's visit related to:

☐ Auto ☐ Work ☐ Fall ☐ Sports injury ☐ Other

If work related, have you made a report of your accident to your employer? ☐ Yes ☐ No

How did you hear about our office?

☐ Referred by (name): _____
☐ Community Event: _____
☐ Saw Sign/Clinic ☐ Google ☐ Bing ☐ Yellowpages.com
☐ Newspaper ☐ Insurance ☐ Facebook ☐ Other: _____

PRIMARY COMPLAINT/CONCERN: _____

(If more than one area of concern, list secondary concerns on the following page)

When did this begin? _____

Cause:_____

Since onset, this has: ☐ Stayed the same

☐ Gotten better ☐ Gotten worse ☐ Comes and goes

What makes this better?

_____

What makes this worse?

_____

Has this occurred before? ☐ No ☐ Yes; Explain:

_____

_____

Have you had any past treatment for this concern?

☐ No ☐ Yes; Type of treatment: _____

Results: _____

Rate this discomfort on a Ø-10 scale

(Ø being no discomfort and 10 being the worst):_____

Describe this discomfort (mark all that apply):

☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning
☐ Sharp ☐ Throbbing ☐ Stabbing Needles ☐ Dull ☐ Achy
☐ Pins and Needles ☐ Tension

Does this discomfort radiate or travel anywhere?

☐ No ☐ Yes; where:_____

How often does this occur?

☐ Constant (76 - 100% of the time) ☐ Frequent (51- 75%)
☐ Occasional (26 - 50%) ☐ Intermittent (0 - 25%)

Does this interfere with:

☐ Daily routine ☐ Work ☐ Sleep ☐ Other activities Please Explain:_____

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SECOND COMPLAINT/CONCERN: _____

When did this begin? _____

Cause: _____

Since onset, this has: ☐ Stayed the same

☐ Gotten better ☐ Gotten worse ☐ Comes and goes

What makes this better?

_____

What makes this worse?

_____

Has this occurred before? ☐ No ☐ Yes; Explain:

_____

_____

Have you had any past treatment for this concern?

☐ No ☐ Yes; Type of treatment: _____

Results: _____

Rate this discomfort on a Ø-10 scale

(Ø being no discomfort and 10 being the worst): _____

Describe this discomfort (mark all that apply):

☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning

☐ Sharp ☐ Throbbing ☐ Stabbing Needles ☐ Dull ☐ Achy

☐ Pins and Needles ☐ Tension

Does this discomfort radiate or travel anywhere?

☐ No ☐ Yes; where: _____

How often does this occur?

☐ Constant (76 - 100% of the time) ☐ Frequent (51- 75%)

☐ Occasional (26 - 50%) ☐ Intermittent (0 - 25%)

Does this interfere with:

☐ Daily routine ☐ Work ☐ Sleep ☐ Other activities

Please Explain: _____

THIRD COMPLAINT/CONCERN: _____

When did this begin? _____

Cause: _____

Since onset, this has: ☐ Stayed the same

☐ Gotten better ☐ Gotten worse ☐ Comes and goes

What makes this better?

_____

What makes this worse?

_____

Has this occurred before? ☐ No ☐ Yes; Explain:

_____

_____

Have you had any past treatment for this concern?

☐ No ☐ Yes; Type of treatment: _____

Results: _____

Rate this discomfort on a Ø-10 scale

(Ø being no discomfort and 10 being the worst): _____

Describe this discomfort (mark all that apply):

☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning

☐ Sharp ☐ Throbbing ☐ Stabbing Needles ☐ Dull ☐ Achy

☐ Pins and Needles ☐ Tension

Does this discomfort radiate or travel anywhere?

☐ No ☐ Yes; where: _____

How often does this occur?

☐ Constant (76 - 100% of the time) ☐ Frequent (51- 75%)

☐ Occasional (26 - 50%) ☐ Intermittent (0 - 25%)

Does this interfere with:

☐ Daily routine ☐ Work ☐ Sleep ☐ Other activities

Please explain: _____

CURRENT MEDICATIONS

_____

_____

_____

MEDICATION ALLERGIES

_____

_____

How would you rate your overall health right now?

☐ poor ☐ fair ☐ good ☐ very good ☐ excellent

Please indicate the type of care desired.

☐ Relief Care – for relief of symptoms/discomfort

☐ Rehabilitative Care – for relief of symptoms as well as correction of the cause of the symptoms

☐ I want the Doctor to select the type of care appropriate for my condition

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ADDITIONAL HEALTH CONDITIONS/CONCERNS (PAST AND PRESENT)

- ☐ Severe or frequent headaches
- ☐ Frequent neck pain
- ☐ Pain between shoulders
- ☐ Lower back problems
- ☐ Scoliosis
- ☐ Numbness or pain in arms/legs/hands
- ☐ Dizziness
- ☐ Loss in vision
- ☐ Blurred vision
- ☐ Hearing loss
- ☐ Ear infections
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Loss of sleep
- ☐ Heart attack
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ High/low blood pressure
- ☐ Heart surgery/pace maker
- ☐ Difficulty breathing
- ☐ Asthma
- ☐ Allergies
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Digestive problems
- ☐ Ulcers/colitis
- ☐ Kidney problems
- ☐ Frequent urination
- ☐ Hepatitis
- ☐ Rheumatic fever
- ☐ Shingles
- ☐ Alcohol/drug abuse
- ☐ HIV/Aids
- ☐ Recent weight loss/weight gain
- ☐ Abnormal bruising/bleeding
- ☐ Irregular or painful menses
- ☐ Anemia
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Anxiety
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Other_____

Are you pregnant?
☐ Yes ☐ No

Are you nursing?
☐ Yes ☐ No

Smoker Status: ☐ Never ☐ Former ☐ Current ☐ Occasional Amount Smoked: _____

	No	Yes	Please explain:
Accidents? (sports, work, auto)	☐	☐	_____
Stress? (work, family, home)	☐	☐	_____
Hospitalizations/surgeries	☐	☐	_____
Major illnesses?	☐	☐	_____
Reoccurring illnesses?	☐	☐	_____
Exercise?	☐	☐	_____
Others? (poor nutrition, loss of sleep)	☐	☐	_____

FAMILY HEALTH HISTORY

A. Grandmother
B. Grandfather
C. Father
D. Mother
E. Aunt/Uncle
F. Sibling (s)
G. Spouse
H. Child

Please check each of the health conditions that a family member has now or has had in the past. Next to any checked box, please insert the corresponding letter to indicate the family member(s) affected by the condition.

- ☐ Headaches
- ☐ Neck/Back pain
- ☐ Diabetes
- ☐ Asthma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Alcohol/drug abuse
- ☐ Depression
- ☐ Anxiety
- ☐ Seizures
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Other _____
- ☐ Other _____

PATIENT AUTHORIZATION

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. If I decide to receive care here, I hereby authorize the Doctor(s) to work with my condition through the use of adjustments as he or she deems appropriate. I clearly understand and agree that all services rendered to me are my financial responsibility. I understand that health and accident insurance policies are an arrangement between myself and my insurance provider. The office does work with insurance companies directly by submitting forms, claims, and notes for reimbursement on behalf of the patient; the amounts authorized to be paid directly to the Doctor's Office will be credited to my account on receipt from insurance companies. In the event that an account becomes delinquent and a collection agency and/or law office is needed to collect on the account, the patient is responsible for all collection costs and/or attorney fees.

Patient (or Guardian) **Signature:**_____ **Date:** _____