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www.abundancechiro.com * 978-921-2225

Name______________________________ Date____/____/_____ Age______ Male / Female

Address______________________________City_______________State______Zip_________

Phone: Home_______________ Cell________________ Work ________________

Email______________________________________ Date of Birth______/______/________

Employer's Name__________________________ Position__________________________

Single / Married / Divorced / Widowed Spouse's Name______________________________

Number of Children_____ Names, Ages & Gender_____________________________________

Who may we thank for referring you?____

To help us serve you better, please complete the following information. We look forward to working with you to build abundant health for you and your family.

CURRENT HEALTH CONCERNS

Please describe the REASON FOR YOUR VISIT: ______________________________________

____

What are some activities you can no longer do because of your current health condition?

____

What is your top health goal?

____

CURRENT PHYSICAL STRESSES

Please describe your usual work position and how long you maintain it during the day? For example do you work at a computer, talk on the phone or stand at a machine for most of the day?

____

Does your job require regular airline travel and hotel stays? Yes / No - If yes, how often? ______________

While at work, do you stand or work on a concrete floor? Yes / No

How long is your commute each day? ________ How many hours do you typically work in a week? ________

How many hours per week do you watch T.V.? ________ Are you sitting or lying on a couch? Yes / No

Please describe your exercise/sports program including type and frequency.

____

How many hours of sleep do you typically get? ________ Do you sleep well? Yes / No

Do you ever sleep on your stomach? Yes / No - How old is your mattress? ________

Do you wear orthotics (foot supports) or a heel lift? Yes / No - If yes, for how many years? ________

Do you use a cervical pillow? Yes / No

Have you received Chiropractic care before? Yes / No - Date of last adjustment_________________

HISTORY OF PHYSICAL TRAUMA

Where were you born? Home / Birth Center / Hospital

Medication used? Yes / No C-Section? Yes / No Forceps/Vacuum? Yes / No

HISTORY OF PHYSICAL TRAUMA (continued)

List any surgeries that you have had: (Please list dates and reason for surgery)

____

____

Significant childhood injuries (fractures, stitches, falls, sports-related, etc.): Please list dates, injury and treatment:

____

____

Significant adult injuries (fractures, stitches, falls, sports-related, etc.): Please list dates, injury and treatment:

____

____

Please tell us about your most recent motor vehicle accident/work-related injury:

Date_____________ Driver / Front passenger / Rear passenger Seatbelt: Y / N Airbag discharged Y / N

Injuries: ____

Care received: ____

Previous motor vehicle accident/work-related injury: Date ________________

Driver / Front passenger / Rear passenger Seatbelt: Y / N Airbag discharged Y / N

Injuries: ____

Care received: ____

HISTORY OF CHEMICAL STRESSES

How many fast food meals do you eat per week? ________

How many alcoholic beverages do you drink per week? ________

Do you smoke tobacco products? Yes / No - If yes, how many per day? ________

Exposed to second hand smoke? Yes / No

How many glasses of water do you drink per day? _______

How many caffeinated beverages (coffee, tea or cola) do you drink per day? _______

Do you consume artificial sweeteners? Yes / No - If yes, how many packets per day? ______

Are you currently on prescription or over the counter drugs? Yes / No

If yes, which ones? ____

Daily dosage? How long? ____

Describe any nutritional supplements that you are taking:

____

How would you rate your current physical health? Excellent / Good / Fair / Poor

HISTORY OF EMOTIONAL STRESSES

Please check any emotional stressors that apply from the list below:

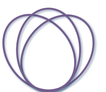
___Childhood ___Friends ___Family ___Parents divorce

___Commuting ___Family ___Verbal Abuse ___Chronic illness or disability

___Finances ___Addictions ___Loss of a loved one ___Spouse/significant other

___School ___Work ___New job ___Divorce/separation

How would you rate your emotional/mental health? Excellent / Good / Fair / Poor



Patient Name: ______________________________ Date: ______________

Below is a list of health issues that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING HEALTH ISSUES YOU HAVE EVER HAD:

- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Eczema
- ❑ Epilepsy
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Influenza
- ❑ Measles
- ❑ Mental Disorders
- ❑ Mumps
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Rheumatic Fever
- ❑ Smallpox
- ❑ Tuberculosis
- ❑ Whooping Cough

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST YEAR:

NERVOUS SYSTEM

- ❑ Nervousness/anxiety
- ❑ Irritability/impatience
- ❑ Depression
- ❑ Attention deficit
- ❑ Stress
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold Extremities

GENERAL

- ❑ Headaches
- ❑ Migraines
- ❑ Loss of Sleep
- ❑ Allergies
- ❑ Fatigue
- ❑ Fibromyalgia

GASTROINTESTINAL

- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Excessive Thirst
- ❑ Excessive Weight
- ❑ Significant Weight Loss
- ❑ Frequent Nausea
- ❑ Gas or Bloating After Meals
- ❑ Heartburn
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Abdominal Cramps
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gallbladder Problems
- ❑ Diagnosed IBS, Chron's, Diverticulitis, Colitis
- ❑ Black/Bloody Stool

MALE/FEMALE

- ❑ Menstral Irregularity
- ❑ Menstral Cramps
- ❑ Vaginal Pain/Infection
- ❑ Breast Pain/Lumps
- ❑ Prstate Dysfunction
- ❑ Infertility Problems
- ❑ Other:______________

FEMALES ONLY

Date of your last period:

____

Are you pregnant?

□Yes □No

GENITO-URINARY

- ❑ Bladder Trouble
- ❑ Discolored Urine
- ❑ Painful Urination
- ❑ Excessive Urination

CARDIOVASCULAR/RESPIRATORY

- ❑ Chest Pain
- ❑ Asthma
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Stroke
- ❑ High Cholesterol

EENT

- ❑ Vision Problems
- ❑ Sinus Infections
- ❑ Earaches
- ❑ Hearing Difficulty
- ❑ Tinnitus

FAMILY HISTORY (CHECK ALL THAT APPLY)

The following family members have the same or similar problem(s) as I do:

☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Sister ☐ Brother

HEALTH INSURANCE INFORMATION
(must be completed before services can be rendered)

NAME:____
First Middle Initial Last

PHONE: Home____________________ Cell__________________ Work__________________

DATE OF BIRTH:____________________MARITAL STATUS: ______________________________

IN CASE OF EMERGENCY CONTACT:____

EMERGENCY CONTACT'S PHONE NUMBER:____

NAME OF PRIMARY INSURANCE CARRIER:_____________________________________

NAME OF INSURED:_______________________ INSURED DATE OF BIRTH:__________________

POLICY NUMBER:________________________

NAME OF SECONDARY INSURANCE CARRIER:___________________________________

NAME OF INSURED:_______________________ INSURED DATE OF BIRTH:__________________

POLICY NUMBER:________________________

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Abundance Chiropractic/ Liz Biehl, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED____ **DATE**__________________________