Point Family
Wellness and Chiropractic

Welcome to Point Family Wellness and Chiropractic! We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Patient General Information

(Please Print in Black or Blue Ink) Today's Date:_______/_______/_________

Name: (First, MI, Last)_______________________ Date of Birth:_______/_______/_________

Home Phone: ______________ Mobile Phone:______________ Other Phone:______________

Gender: ☐ Male ☐ Female Email:______________ Contact Method *(check one)* ☐ H📞 ☐ M📞 ☐ O📞 ☐ E@

SSN:________-________-________ Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Other__________

Marital Status: ☐ Single ☐ Married ☐ Other Preferred Language: ☐ English ☐ Other__________

Address:______________________ City, State, Zip:______________________

Occupation:______________________ Employer:______________________

Spouse's Name:______________ Spouse's Occupation:______________ Spouse's Employer:______________

Names and Ages of Children:______________________________________

Emergency Contact:______________ Relationship:______________ Phone:______________

How were you referred:______________________ Appointment Reminders: ☐ Email ☐ Text

Have you seen a Chiropractor before: ☐ Yes ☐ No *(If yes, who?)* ______________________

Insurance Information

☐ Insurance ☐ Cash

Insurance Company:______________ Policy Number:______________ Group Number:______________

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian Policy Holder's Name:______________

Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's Date of Birth:_______/_______/_________

Policy Holder's Address:______________________ City, State, Zip:______________________

History of Present Illness

Date of injury:______________________ Date Symptoms Appeared:______________________

What are your current complaints:______________________________________

How did your problem begin:______________________ ☐ Suddenly ☐ Gradual ☐ Post Injury

Have you ever had the same condition: ☐ Yes ☐ No Have you seen another provider for this condition: ☐ Yes ☐ No

Since the condition began are the symptoms:

☐ Increasing ☐ Decreasing ☐ Not changing

What percent of the day are symptoms felt:

☐ 0 – 25 ☐ 25 – 50 ☐ 50 – 75 ☐ 75 – 100

What makes your symptoms better:

____

What makes your symptoms worse:

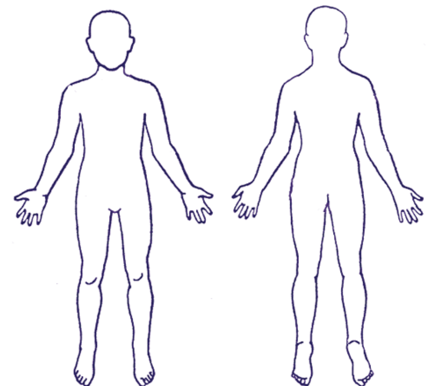
____

Rate the severity of your pain: *(0 = No Pain, 10 = A lot of Pain)*

0 1 2 3 4 5 6 7 8 9 10

Mark the areas on this body where you feel the described sensations. Please use the appropriate symbols .

))))))	Aching
xxxx	Burning
oooo	Dull
: : : :	Sharp
/////	Stabbing
++++	Throbbing
*****	Numbness/Tingling



Social History

What are your hobbies:____

Do you use tobacco products: ☐ Yes ☐ Former smoker ☐ Never been a smoker If yes, how many packs per day:__________

If you are a former smoker, how long has it been since quitting:____________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how often?________________________

Do you exercise: ☐ Yes ☐ No If yes, in what way:____

Medical History

Please list any Hospitalizations, Auto Accidents, Surgeries, Serious Illness, or Serious Injuries:

Date:_______________Briefly Explain:____

Date:_______________Briefly Explain:____

Please list any known allergies:____

Current Medications and Supplements: *(Please include prescription and over the counter medications)*

Medication	Reason	Supplements

Family Health History

Please indicate if a family member (parent, sibling, or child) has had or currently has any of the following conditions:

☐Arthritis ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Cancer

If deceased, please list cause of death:____

Medical Conditions

Please indicate if you've had or presently have any of the following conditions: ☐ Acid Reflux ☐ ADD/ADHD ☐ Allergies

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer ☐ COPD ☐ Constipation ☐ Depression ☐ Diabetes

☐ Headaches ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Liver Disease ☐ Osteoporosis ☐ Renal Disease

☐ Seizure ☐ Stroke ☐ Thyroid Disease ☐ Ulcers ☐ Other____________

Health Goals

What are your top three health goals:

1.____________________________2. ____________________________3.____________________________

What would you like to gain from chiropractic care? ☐ Resolve existing condition ☐ Overall wellness ☐ Both

Do you have any health concerns for other family members today?______________________________

Are you open to other therapies to help improve your care? ☐ Acupuncture ☐ Massage ☐ Nutrition

Signature

I certify this information is true and correct to the best of my knowledge. I will notify Point Family Wellness and Chiropractic of any changes in my status or the above information. I consent to a chiropractic evaluation and treatment by the doctor.
I understand that any fee for service rendered is due at the time of service.

Patient Signature:____Date:____________________

Guardian Signature:_______________________________________Date:____________________

Physician Signature:_______________________________________Date:____________________

Vitals (OFFICE USE ONLY)

Height:________Weight:__________ Pulse:______ Resp:___________Temp:_____BP:_____/_____BMI:________