Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____City: _____ State: _____ Zip: _____

E-mail Address: _____ Mobile Phone:_____

Marital Status: ( ) Single ( ) Married Do you have Insurance: ☐Yes ☐ No

Occupation: _____Number of children and Ages:_____

Name & Number of Emergency Contact: _____ _____ Relationship:_____

Height _____ Weight _____

Whom may we thank for referring you to this office _____?

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	≥8 hours/night	Insomnia

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Fibromyalgia	Asthma	Osteoporosis	

Surgeries: (Circle all that apply to you)

Appendectomy	cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	GallBladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	HerniaBreast Augmentation

Other _____

Please list all current medications/vitamins:

_____

_____

_____

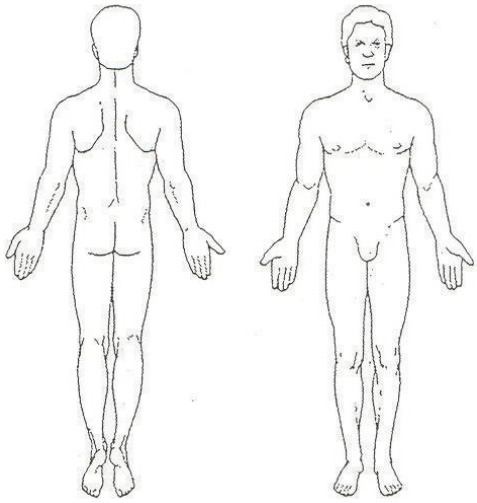
_____

_____

- What is the reason for your visit today?□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____
- What caused this complaint(s)?_____

_____

- When did this complaint begin? _____/_____/_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and goes
- What does your complaint (s) feel like? Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other_____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain Moderate Pain Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

- What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____
- What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching /Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____
- What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching/ Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_____
- How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □100% of the day Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping□ During activities □ After activities □ Symptoms are constant and do not change □ Other:_____
- Have you seen any other doctor for this complaint? □ Yes □ No If "Yes", please provide the following information:

Doctor's name:_____ Date consulted:_____Diagnosis_____

- Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel /Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

Review of Systems -(Check box if you have had trouble with any of the following)

	Past	Present	No		Past	Present	No
Headache				Depression			
Dizziness				Anxiety			
Prostate Problems				Stress			
Heartburn				Arthritis			
Frequent Cold/Flu				Joint Stiffness			
Loss of Balance				Gall Bladder Problems			
Jaw Pain/TMJ				Constipation /Diarrhea			
High Blood Pressure				Colon issue			
Difficulty Sleeping				PMS			
Ringing in Ears				Sinus			
Bed Wetting				Foot or Knee Problems			
Menstrul Problems							
Low Blood Pressure				Digestive problems			
Chest Pain				Ulcers			
Menopause Problems				Allergies			
Asthma				Kidney Disease			

ACTIVITIES OF LIFE

ACTIVITIES:	EFFECT:			
Carrying/Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Informed Consent for Chiropractic Care

Patient_____
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including x-rays on me (or on the patient named below, for whom I am legally responsible) at **Chiro4All** office.

1. The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.
2. I understand that I will be examined and cared for by licensed doctors of chiropractic.
3. **Doctor Alae Rabiei** uses only chiropractic methods that are taught in accredited chiropractic colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.
4. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all of the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts known, and in my best interests.
5. I have read, or have had read to me, the above consent. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of care now and in the future. I am free to withdraw my consent and discontinue care at any time.

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding **broken and/or cancelled appointments**. The therapeutic benefit of each visit builds on the previous visit; therefore we discourage cancellations unless absolutely necessary. Please remember that we have reserved appointment times especially for you and these appointments are a commitment for your benefit. If you need to cancel an appointment, we request **at least 24 hours' notice**. This will enable us to reschedule your appointment and to offer your cancelled time to other patients that desire to get their treatment. When you cancel your appointment at the last minute, everyone loses especially you, the doctor and other patients that would like to have utilized your appointment time.

Unfortunately, due to the recent number of no-shows, we are implementing a no-show policy. In the case of an appointment where the patient does not call to cancel and does not come to the appointment, the office will charge a **no-show fee of $35.00.**

_____ _____/_____/_____

Patient/ Guardian Signature: **Date:**