NAME_____ DATE_____

Help Us Understand Your Health

And Wellness Goals

Choosing chiropractic care is an exciting step towards regaining or improving your health and wellness. Old injuries, emotional tension, work and family situations along with poor dietary choices add to your daily stress load. This can cause muscles to overreact and joints within the spine to lock. However, our greatest concern is when those ongoing stressful habits affect the inner nerve connections, leaving you at risk for deeper health problems. Unwinding harmful spinal stress while coaching you towards a strong and vibrant lifestyle is what we love to do!

Our office is unique because we use a sophisticated scanning system to detect hidden stress patterns. This accurate, computer-based analysis rates your stress on a scale from 0-100 and is known as the **COREscore™**.

Please answer the following questions so we may better understand how to help you:

1. On a scale of 1 to 10 (10 being the most important) how important is your health to you? _____

On the COREscore™ chart to the right:

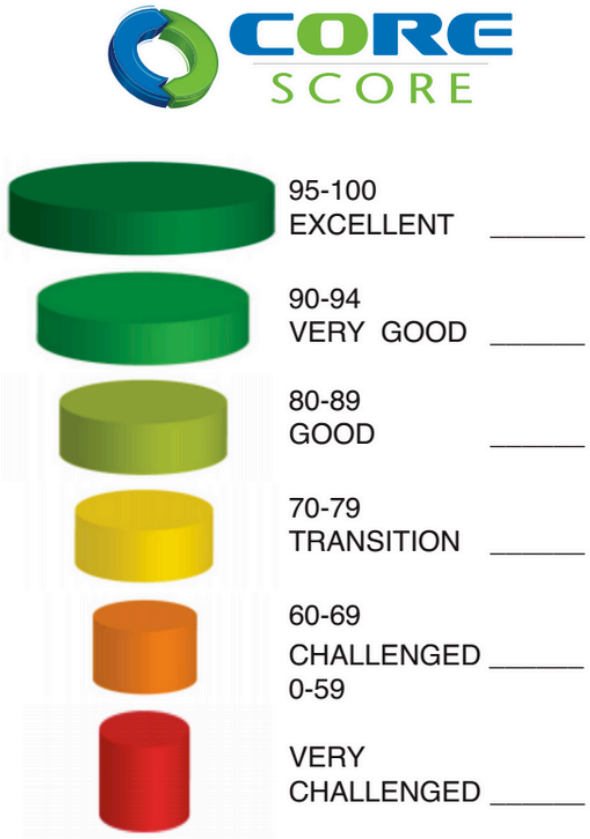
2. Please put an 'X' to score where you think you are today.

3. Please circle where you would like to be (your goal).

4. **How long** do you think it might take to get to where you circled? _____

5. What things might you need to change to help you reach your goal?
   a. _____
   b. _____
   c. _____
   d. _____

6. If we could make recommendations that would not only address your main concerns, but could also help you with improving your overall health, would you like to hear them?
   _____ yes _____ no



HEALTH QUEST

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

APPLICATION FOR CARE AT HEALTH QUEST CHIROPRACTIC

Today's Date: _____ CTN: _____

PATIENT DEMOGRAPHICS

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

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Work Phone: _____

Employer: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No

Spouse's Name _____ Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

Name of Previous Chiropractor: _____ Last Visit Date:_____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Health Quest Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Health Quest Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ CT#: _____ ___/___/___

Activities of Daily Living/Symptoms/Medications

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Autism Spectrum	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Ear Infections	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:_____

_____

_____

INITIAL CENTRAL NERVOUS SYSTEM PROFILE

When was your most recent auto accident (Date)? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures?_____

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"