



ADULT – NEW PATIENT INTAKE

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Complete ALL Sections below. Highlighted Areas MUST be completed; if anything does not apply to you, put "N/A."

PATIENT INFORMATION

First Name: Middle Name: Last Name:
DOB: Age: SSN:
Sex: MALE / FEMALE Height: Weight:
Primary Language: Ethnicity: Marital Status:
Spouse Name: Spouse Occupation: Employer:
of Children: First Name & Age of Children:
Your Occupation: Employer: Work Phone:
Work Address:
City: State: Zip Code:
Home Phone: Cell Phone: Cell Provider:
Home Address:
City: State: Zip Code:
Email:
Would you like to receive Appointment Reminders via:
How did you hear about PCW?
Do we have your permission to use your first name to thank who referred you?

EMERGENCY CONTACT & GUARDIAN INFORMATION (if Patient is Under 18)

Emergency Contact Full Name: Relationship:
DOB: Age: Phone:
Emergency Contact Full Name: Relationship:
DOB: Age: Phone:

Consent to Care for Minor: I certify that I am the parent or legal guardian of the minor listed above. I authorize the doctor(s) of PCW to administer evaluation and care, and whomever they may designate as an assistant to administer evaluation, to my son/daughter.

Signature: Date:

X-RAY RELEASE

I understand that specific postural x-rays may be necessary for the identification of the location, presentation, and severity of Vertebral Subluxation. X-Rays may also be utilized to show progress after a period of recommended chiropractic care. Therefore, I authorize Precision Chiropractic & Wellness, or a certified employee has my permission to perform an X-ray evaluation.

Signature: Date:

Female Patients: To the best of my knowledge, I am not pregnant, and I have been advised that x-ray can be hazardous to an unborn child.

Is there any Chance of Pregnancy? YES NO If Yes, How many Weeks?

Are you trying / planning? YES NO Are you currently having a menstrual cycle? YES NO

If YES, Start Date: If NO, Date of Last Cycle Ended:

PRIMARY COMPLAINT – Please describe ONLY your Main Complaint Below

Is this Complaint a: Auto-Accident Work-Related Injury Personal-Injury Claim **Date of Incident:** ____ / ____ / ____

Describe your Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where your Complaint is located →

Ex. Neck Pain →



Please check the box(es) that best describe your discomfort:

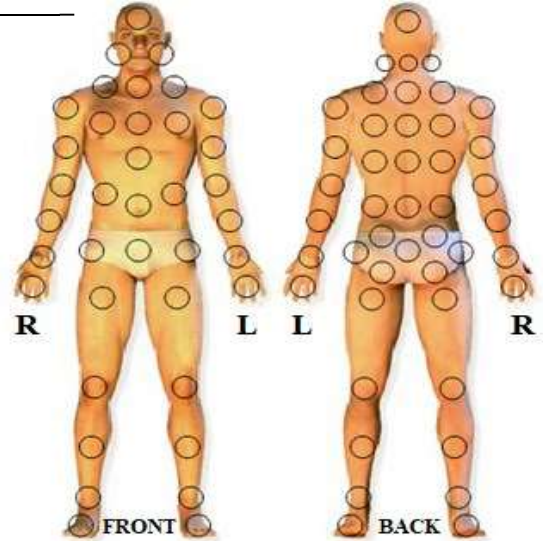
- Achy Burning Boring Cramping Deep Dull
 Numb Pressure Radiating Random Restricted Sharp
 Stiff Superficial Throbbing Tight Tingling Weak

Does it travel, radiate, and/or extend anywhere? YES NO

If YES, where to? _____

How LONG have you experienced it? ____ days ____ weeks ____ months ____ years

Have you EVER had this Complaint before? YES NO



How OFTEN do you feel this Complaint? Constant Daily Weekly Monthly Yearly

How LONG does this Complaint last when felt? 0 – 10% 15 – 25% 30 – 50% 55 – 75% 80 – 100%

Rate the Intensity at its WORST level: 0 1 2 3 4 5 6 7 8 9 10

Rate the Intensity at its LOWEST level: 0 1 2 3 4 5 6 7 8 9 10

Is the Complaint Changing at all? Getting Better Getting Worse Not Changing

Is the Complaint worse: In the Morning During the Day At Night Same All Day

What Makes this Complaint WORSE? Bowel Movements Breathing Coughing Exercise Lying Down
 Sitting Down Sneezing Standing Stretching Walking

What Makes this Complaint BETTER? Chiropractic Care Heat Ice Lying Down Medication
 Resting Sitting Down Standing Stretching Walking

Rate your Stress Level & IF the complaint Impacts it: Mild Stress Moderate Stress Significant Stress
 No Stress YES, it affects my stress. NO, it does not affect it.

How is your Complaint affecting your Daily Life/Activities? Home Duties (ex. Cooking) Self-Care (ex. Bathing)
 Relationships (ex. Spouses) Need Assistance
 Totally Impaired / Disabled No Effect

Is the Complaint Affecting your Work / Student Status? No Effect Off Work / School
 Restrictions, Full Time Unemployed
 Restrictions, Part Time Retired

Have you had help for this before us? Chiropractic Medication Physical Therapy Surgery Other: _____

Name of Doctor or Clinic: _____ Date of Last Treatment: ____ / ____ / ____

SECOND COMPLAINT – Please describe ONLY your 2nd Complaint Below

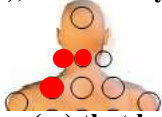
Is this Complaint a: Auto-Accident Work-Related Injury Personal-Injury Claim **Date of Incident:** ____ / ____ / ____

Describe your Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where your Complaint is located →

Ex. Neck Pain →



Please check the box(es) that best describe your discomfort:

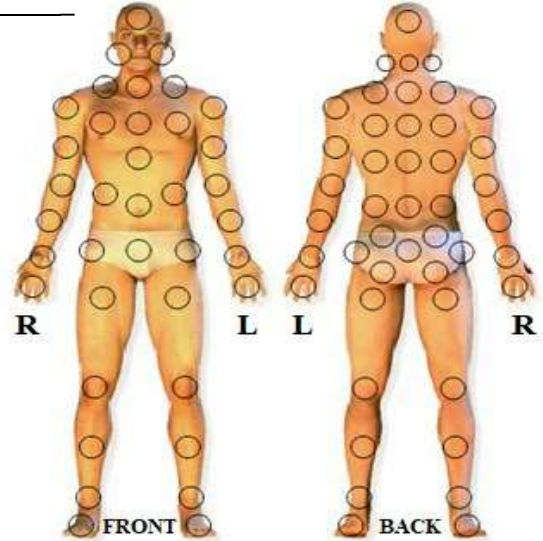
- Achy Burning Boring Cramping Deep Dull
 Numb Pressure Radiating Random Restricted Sharp
 Stiff Superficial Throbbing Tight Tingling Weak

Does it travel, radiate, and/or extend anywhere? YES NO

If YES, where to? _____

How LONG have you experienced it? ____ days ____ weeks ____ months ____ years

Have you EVER had this Complaint before? YES NO



How OFTEN do you feel this Complaint? Constant Daily Weekly Monthly Yearly

How LONG does this Complaint last when felt? 0 – 10% 15 – 25% 30 – 50% 55 – 75% 80 – 100%

Rate the Intensity at its WORST level: 0 1 2 3 4 5 6 7 8 9 10

Rate the Intensity at its LOWEST level: 0 1 2 3 4 5 6 7 8 9 10

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Is the Complaint worse: In the Morning During the Day At Night Same All Day

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Rate your Stress Level & IF the complaint Impacts it: Mild Stress Moderate Stress Significant Stress
 No Stress YES, it affects my stress. NO, it does not affect it.

How is your Complaint affecting your Daily Life/Activities? Home Duties (ex. Cooking) Self-Care (ex. Bathing)
 Relationships (ex. Spouses) Need Assistance
 Totally Impaired / Disabled No Effect

Is the Complaint Affecting your Work / Student Status? No Effect Off Work / School
 Restrictions, Full Time Unemployed
 Restrictions, Part Time Retired

Have you had help for this before us? Chiropractic Medication Physical Therapy Surgery Other: _____

Name of Doctor or Clinic: _____ Date of Last Treatment: ____ / ____ / ____

THIRD COMPLAINT – Please describe ONLY your 3rd Complaint Below

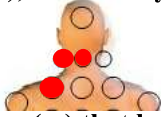
Is this Complaint a: Auto-Accident Work-Related Injury Personal-Injury Claim **Date of Incident:** ____ / ____ / ____

Describe your Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where your Complaint is located →

Ex. Neck Pain →



Please check the box(es) that best describe your discomfort:

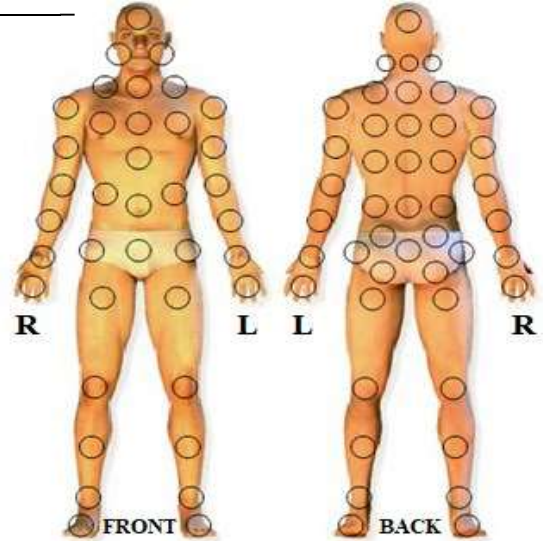
- Achy Burning Boring Cramping Deep Dull
 Numb Pressure Radiating Random Restricted Sharp
 Stiff Superficial Throbbing Tight Tingling Weak

Does it travel, radiate, and/or extend anywhere? YES NO

If YES, where to? _____

How LONG have you experienced it? ____ days ____ weeks ____ months ____ years

Have you EVER had this Complaint before? YES NO



How OFTEN do you feel this Complaint? Constant Daily Weekly Monthly Yearly

How LONG does this Complaint last when felt? 0 – 10% 15 – 25% 30 – 50% 55 – 75% 80 – 100%

Rate the Intensity at its WORST level: 0 1 2 3 4 5 6 7 8 9 10

Rate the Intensity at its LOWEST level: 0 1 2 3 4 5 6 7 8 9 10

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 No Stress YES, it affects my stress. NO, it does not affect it.

How is your Complaint affecting your Daily Life/Activities? Home Duties (ex. Cooking) Self-Care (ex. Bathing)
 Relationships (ex. Spouses) Need Assistance
 Totally Impaired / Disabled No Effect

Is the Complaint Affecting your Work / Student Status? No Effect Off Work / School
 Restrictions, Full Time Unemployed
 Restrictions, Part Time Retired

Have you had help for this before us? Chiropractic Medication Physical Therapy Surgery Other: _____

Name of Doctor or Clinic: _____ Date of Last Treatment: ____ / ____ / ____

FOURTH COMPLAINT – Please describe ONLY your 4th Complaint Below

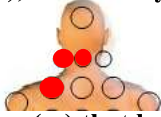
Is this Complaint a: Auto-Accident Work-Related Injury Personal-Injury Claim **Date of Incident:** ____ / ____ / ____

Describe your Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where your Complaint is located →

Ex. Neck Pain →



Please check the box(es) that best describe your discomfort:

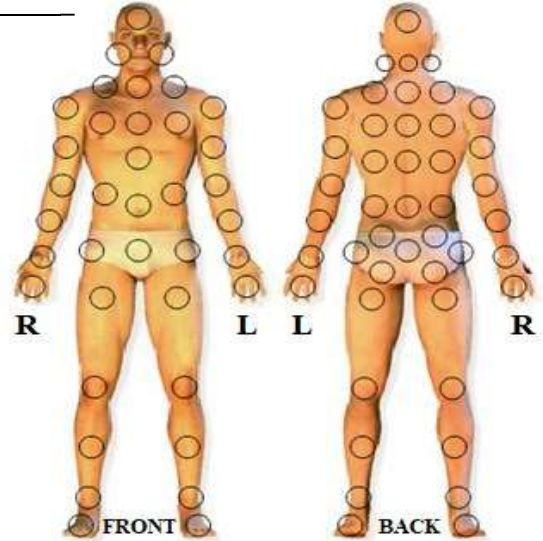
- Achy Burning Boring Cramping Deep Dull
 Numb Pressure Radiating Random Restricted Sharp
 Stiff Superficial Throbbing Tight Tingling Weak

Does it travel, radiate, and/or extend anywhere? YES NO

If YES, where to? _____

How LONG have you experienced it? ____ days ____ weeks ____ months ____ years

Have you EVER had this Complaint before? YES NO



How OFTEN do you feel this Complaint? Constant Daily Weekly Monthly Yearly

How LONG does this Complaint last when felt? 0 – 10% 15 – 25% 30 – 50% 55 – 75% 80 – 100%

Rate the Intensity at its WORST level: 0 1 2 3 4 5 6 7 8 9 10

Rate the Intensity at its LOWEST level: 0 1 2 3 4 5 6 7 8 9 10

Is the Complaint Changing at all? Getting Better Getting Worse Not Changing

Is the Complaint worse: In the Morning During the Day At Night Same All Day

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Rate your Stress Level & IF the complaint Impacts it: Mild Stress Moderate Stress Significant Stress
 No Stress YES, it affects my stress. NO, it does not affect it.

How is your Complaint affecting your Daily Life/Activities? Home Duties (ex. Cooking) Self-Care (ex. Bathing)
 Relationships (ex. Spouses) Need Assistance
 Totally Impaired / Disabled No Effect

Is the Complaint Affecting your Work / Student Status? No Effect Off Work / School
 Restrictions, Full Time Unemployed
 Restrictions, Part Time Retired

Have you had help for this before us? Chiropractic Medication Physical Therapy Surgery Other: _____

Name of Doctor or Clinic: _____ Date of Last Treatment: ____ / ____ / ____

Do you have any Additional Complaints to Report that you would like our help with? YES, I have more. NO, not currently.

PATIENT HEALTH HISTORY

Primary Care Physician Full Name: _____

Clinic Name: _____ **Clinic Phone:** (____) - ____ - _____

Clinic Address (City, State, Zip): _____

Please List ALL Medications, including their Name, Dosage & Reason you have been Prescribed them. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your doctor.

- 1. _____ **Dosage:** _____ **Reason:** _____
- 2. _____ **Dosage:** _____ **Reason:** _____
- 3. _____ **Dosage:** _____ **Reason:** _____
- 4. _____ **Dosage:** _____ **Reason:** _____
- 5. _____ **Dosage:** _____ **Reason:** _____
- 6. _____ **Dosage:** _____ **Reason:** _____
- 7. _____ **Dosage:** _____ **Reason:** _____
- 8. _____ **Dosage:** _____ **Reason:** _____
- 9. _____ **Dosage:** _____ **Reason:** _____
- 10. _____ **Dosage:** _____ **Reason:** _____

Please List ALL Nutrients & Supplements, including their Name, Amount & Reason are taking them. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

- 1. _____ **Amount:** _____ **Reason:** _____
- 2. _____ **Amount:** _____ **Reason:** _____
- 3. _____ **Amount:** _____ **Reason:** _____
- 4. _____ **Amount:** _____ **Reason:** _____
- 5. _____ **Amount:** _____ **Reason:** _____
- 6. _____ **Amount:** _____ **Reason:** _____
- 7. _____ **Amount:** _____ **Reason:** _____
- 8. _____ **Amount:** _____ **Reason:** _____
- 9. _____ **Amount:** _____ **Reason:** _____
- 10. _____ **Amount:** _____ **Reason:** _____

Past Surgeries (Reason, Procedure & Date): _____

Auto Accident(s)? YES NO **Hospitalized?** YES NO **Date(s):** _____

Broken Bone(s)? YES NO **Hospitalized?** YES NO **Date(s):** _____

Sprains &/or Strains(s)? YES NO **Hospitalized?** YES NO **Date(s):** _____

Stroke(s)? YES NO **Hospitalized?** YES NO **Date(s):** _____

FAMILY HEALTH HISTORY

Please review the listed health issues/conditions below and **Place "X"** in the Appropriate Column that applies for **"Y"** – Yourself, **"GM"** – Grandmother, **"GF"** – Grandfather, **"M"** – Mother, **"F"** – Father, **"B"** – Brother, **"S"** – Sister and **"C"** – Child.

CONDITION	Y	GM	GF	M	F	B	S	C	CONDITION	Y	GM	GF	M	F	B	S	C	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HYPERthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HYPOthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Your lifestyle, diet and exercise habits play an extremely important role in your overall health and risk of chronic disease. The following questions are designed to help us understand your habits, desires as well as commitments to make changes to those habits if necessary.

How OFTEN do you Exercise? Daily Weekly Never

What Intensity? Light Moderate Strenuous

What Type of Exercise? _____

Hours Per Week? _____

How much water do you drink a day? _____, 8-oz. glasses

What kind? Bottled Distilled Filtered Tap

How many times do you eat Fast Food each week? _____

How often do you have Soda? Daily Weekly Never

How often do you have Coffee? Daily Weekly Never

How often do you have Tea? Daily Weekly Never

How often do you take Recreational Drugs? Daily Weekly Never

How often do you take Over-Counter Medication? Daily Weekly Never **What do you take?** _____

How often do you have Alcohol? Daily Weekly Never **What & How much at a time?** _____

Do you use Tobacco Products? Daily Weekly Never **What & How much at a time?** _____

Year of Use: _____ **Did you Quit use of Tobacco Products?** YES NO **Years Since Quitting:** _____

HEALTH CHECKLIST – REVIEW OF SYMPTOMS & SYSTEMS

Please review the listed below of Symptoms or Health Conditions. Please **Check or “X”** under **Current** if you currently are experiencing the symptom / condition or under **Past** if you have EVER experienced it in before no matter how long ago.

Current	Past	Symptom / Condition	Current	Past	Symptom / Condition
<input type="checkbox"/>	<input type="checkbox"/>	Fevers &/or Chills	<input type="checkbox"/>	<input type="checkbox"/>	Dry Cough
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Getting to Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Productive Cough
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Staying Asleep	<input type="checkbox"/>	<input type="checkbox"/>	Wet Cough
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Up Blood
<input type="checkbox"/>	<input type="checkbox"/>	Weakness / Lack of Strength	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Low Energy	<input type="checkbox"/>	<input type="checkbox"/>	Fast Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Painful Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Skin Rashes (such as Eczema)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Skin Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Skin Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Orthostatic Hypotension
<input type="checkbox"/>	<input type="checkbox"/>	Sores &/or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing Lying Down
<input type="checkbox"/>	<input type="checkbox"/>	Hair & Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (“Heart Skipping a Beat”)
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Awake from Sleep with Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Struck Unconscious	<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowel Habits
<input type="checkbox"/>	<input type="checkbox"/>	Earache(s)	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss &/or Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Change in Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Ear Drainage	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, With Acidic Foods
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in the Ears (Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, With Fatty Foods
<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain &/or Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, In-Between Meals
<input type="checkbox"/>	<input type="checkbox"/>	Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, 30 minutes to 1 hour after Eating
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, When Lying Down
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding / Blood When Whipping
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Urgency to Urinate
<input type="checkbox"/>	<input type="checkbox"/>	Redness of the Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone(s)
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pressure &/or Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection(s)
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Candida or other Fungal Infection(s)
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from Nose	<input type="checkbox"/>	<input type="checkbox"/>	Genital Sores – Male & Female
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	STD’s – Male & Female
<input type="checkbox"/>	<input type="checkbox"/>	Thrush – Oral Fungal Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	Pain with Sex – Male & Female
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Testicle Pain – Male Only
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Testicle Masses or Lumps – Male Only
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tongue	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction – Male Only
<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Genital Discharge – Male & Female
<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps – Male & Female	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps, During Day
<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain – Male & Female	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps, Wake You At Night
<input type="checkbox"/>	<input type="checkbox"/>	Nipple Discharge – Male & Female	<input type="checkbox"/>	<input type="checkbox"/>	Calf Pain with Walking
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer – Male & Female	<input type="checkbox"/>	<input type="checkbox"/>	Calf Pain with Stairs
<input type="checkbox"/>	<input type="checkbox"/>	Mastectomy – Male & Female	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Calves
<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding Currently – Female Only	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Ankles
<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding Difficulties – Female Only	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Feet

HEALTH CHECKLIST – CONTINUED

Current	Past	Symptom / Condition	Current	Past	Symptom / Condition
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sweat Easily
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	Strong Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Wrist-Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	<input type="checkbox"/>	Mid-Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands & Feet
<input type="checkbox"/>	<input type="checkbox"/>	Low-Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	PMS – Female Only
<input type="checkbox"/>	<input type="checkbox"/>	Hip-Thigh Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menopause – Female Only
<input type="checkbox"/>	<input type="checkbox"/>	Knee-Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis – Female Only
<input type="checkbox"/>	<input type="checkbox"/>	Ankle-Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cysts – Female Only
<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems – Male Only
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Infertility or Sterility – Male & Female
<input type="checkbox"/>	<input type="checkbox"/>	Redness of Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Menstrual Cycles
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Cycles
<input type="checkbox"/>	<input type="checkbox"/>	Sport Injury(s)	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Cramping &/or Pain with Cycles
<input type="checkbox"/>	<input type="checkbox"/>	Fracture(s)	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/> Food Allergies / Sensitivities – List Below:		
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Bleed Easily, Does not Stop Quickly	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Slow to Heal after cuts or skin wounds	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Confusion &/or Memory Loss	<input type="checkbox"/> Medication Allergies – List Below:		
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Uncontrolled Falling	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Passing Out	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Speaking	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Seizures &/or Convulsion	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Spinning &/or Vertigo	<input type="checkbox"/> Other Allergens – List Below:		
<input type="checkbox"/>	<input type="checkbox"/>	Tremors	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety &/or Depression	_____		

STRESS ASSESSMENT

Physical	<input type="checkbox"/>	Birth Traumas (Mother & / or Child)	<input type="checkbox"/>	Sitting on Wallet in Back Pocket for Year
	<input type="checkbox"/>	Sleeping on Stomach	<input type="checkbox"/>	Extensive Computer Work
	<input type="checkbox"/>	Repetitive Bending & Lifting	<input type="checkbox"/>	Carrying Heavy Purse / Backpack / Child
	<input type="checkbox"/>	Minimal / No Exercise	<input type="checkbox"/>	Continuous Hours of Sitting / Standing
	<input type="checkbox"/>	Poor Posture	<input type="checkbox"/>	Extensive Cell Phone or Tablet Use
Chemical	<input type="checkbox"/>	Chemical Exposure (At Work or Near Home)	<input type="checkbox"/>	Live Near Chemical or Energy Facilities
	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Second-Hand Smoke Exposure
	<input type="checkbox"/>	Poor Diet	<input type="checkbox"/>	Excessive Sugar / Artificial Sweeteners Use
	<input type="checkbox"/>	Excessive Caffeine	<input type="checkbox"/>	Excessive Salt Usage
	<input type="checkbox"/>	Prescription Medication Use	<input type="checkbox"/>	Over-the-Counter Drug Use (ex. Ibuprofen)
Emotional	<input type="checkbox"/>	Difficulties with Relationships	<input type="checkbox"/>	Career Difficulties
	<input type="checkbox"/>	Difficulties with Children	<input type="checkbox"/>	Suppressed Feelings
	<input type="checkbox"/>	Sick Loved One(s)	<input type="checkbox"/>	Loss of Love One(s)

Which do you feel is your primary stress? Physical Chemical Emotional

Please Explain Why: _____

FINANCIAL RESPONSIBILITY**INITIALS:** _____

By signing below, I recognize that I am financially responsible for all services rendered to me regardless of my insurance plan and/or benefits. ***I understand that Precision Chiropractic & Wellness is a Point-Of-Service Office;*** I understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment up front at the time of service. I understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. ***I am responsible for submitting any insurance claim to my insurance to request reimbursement from an out-of-network provider.*** PCW will assist the process by preparing any necessary reports and forms required for me to collect from the insurance company.

I hereby authorize the Precision Chiropractic & Wellness to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions.

APPOINTMENT POLICIES**INITIALS:** _____

Appointment Changes: A **24 hr. advanced notice** is required for all appointment changes including but not limited to ***Cancellations, Rescheduling's, and/or Changing Appointments.*** The 24-hr. notice gives us an opportunity to serve another member of our community with care.

Late Changes that are less than 24-hr. advanced notice, will be subject to a **\$15.00 fee** for a visit that consists of an Adjustment and/or **\$30.00 fee** for a visit that includes any examination (i.e., new patient examination, progress examination and/or x-ray analysis). All fees must be paid before receiving or scheduling another service.

We understand unexpected circumstances happen and may waive the fee on a case-by-case basis. Medical and family emergencies will never result in fees when brought to PCW's attention. Workplace and other unforeseen schedule conflicts must be brought to PCW's attention to be considered for a fee waiver.

Missed Appointments: Missed Appointments that were not cancelled, changed, or rescheduled with Precision Chiropractic & Wellness **24-hrs. prior** to the scheduled time, i.e., a ***"No-Call, No-Show"*** will result in an **automatic full appointment charge fee** of services that were scheduled to be provided on that appointment time & date.

We understand that unexpected circumstances occur and waiving of fees will be assessed on a case-by-case basis and only considered ***if the patient calls the same business day*** within PCW's business hours (found at www.pcwchiro.com). After business hour calls do not apply. This fee must be paid before receiving or scheduling another service and if said balance is not settle, PCW reserves the right to refuse to provide services and/or care.

PAYMENT POLICIES**INITIALS:** _____

Card Payments: PCW accepts most major Debit & Credit Cards with an additional *transaction fee of 2.8%* for processing.

Declined Payments: If payment is declined (card exp., returned/declined checks, etc.) there is a *\$20.00 fee*.

Late Payments: Payments that are *14 days past due are considered late* unless other arrangements have been made between you and Precision Chiropractic & Wellness.

Over-Due Balances: *15% of total due balance* is added *every 30 days* past due. If your account has an outstanding balance, no future appointments will be scheduled until said balance has been paid in full.

Collections: Balances not paid after *12 Late Periods (360 Days)* will be sent to Collections to be settled.

AUTO-DRAFT AUTHORIZATION**INITIALS:** _____

YES, I AGREE: By *checking Yes and signing below*, I am authorizing Dr. Joshua Holda, D.C. and Precision Chiropractic & Wellness located at either address below to automatically draft payments from my **card on file** following any accumulation of charges or fees defined under *Financial Responsibility, Appointment Policies, Payment Policies and Office Procedures* found above. I understand that I will only be charged if I violate any of these terms and no additional charges will be filed without my notification.

NO, I DECLINE: By *Checking No and signing below*, I understand that I am denying my ability to place a card on file for the use of settling any accumulation of charges or fees defined under *Financial Responsibility, Appointment Policies, Payment Policies and Office Procedures* found above. I understand that I will be subjected to the *Over-Due Balance* fees and *Collections* policy if I do not settle my balance with PCW.

OFFICE PROCEDURES**INITIALS:** _____

Video Recording: I authorize the Doctor of Chiropractic and anyone working in the Precision Chiropractic & Wellness office authorized by the Chiropractor, permission to record my visit or gait pattern **upon request** for the use of analysis and my care.

No Cell Phones or Other Recording Devices: Patients are not allowed recording devices within this clinic with the sole exception of the waiting room area (this exception does not include changing, examination or treatment rooms).

X-Ray Imaging Copies: At your request, you can receive a copy of your x-rays to a disc for a fee of *\$10.00* per x-ray series that is requested. A **Record Release** request form must be on file before these can be released to the patient or pre-approved third-party.

Nutritional Supplementation/Counseling: I understand that the purpose of a nutritional protocol is to provide special food concentrates for dietary purposes. I understand that these protocols are not intended to diagnose or cure any disease. PCW's policy is that nutritional supplements are not refundable or exchangeable due to the maintenance of quality control of our inventory.

Testimonial Consent: PCW celebrates and displays chiropractic testimonials in our office, our website and on our social media outlets to educate others about the benefits of chiropractic care. Please CHECK if you wish to allow us to share your success. **Yes, I DO** **No, I DO NOT**

PATIENT CONSENT**INITIALS:** _____

For use and/or disclosure of protected health information to carry out Analysis, treatment, payment, and healthcare operations:

1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
 - Postcards and other material mailed to the addresses I have provided.
 - Telephoning me at the numbers I have provided and leaving messages on the answer machines or with the individual answering the phone.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.
5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.
6. I understand that this consent is valid while I am a patient on file in this office and written consent need only be obtained once. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already acted in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.
7. By Initialing Above and Signing Below, I authorize Precision Chiropractic & Wellness and it's employees to utilize ALL of my health records on file to be utilized at the discretion of PCW for activities such as but not limited to office education, marketing, student education, and seminar education. Checking here, I also give PCW the ability to record my visits upon verbal agreement to be recorded, to utilize said recordings and my health records to consult with other healthcare professionals when necessary for my case.
8. I give Precision Chiropractic & Wellness permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.
9. The doctor recommends that my spouse be present at my report of findings visit; therefore, I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

TERMS OF ACCEPTANCE**INITIALS:** _____

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease or conditions. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you and when recommend any necessary referral to the appropriate health care provider. Regardless of what the disease or conditions is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints, and organ systems the nerve supplies.

Chiropractic—like any other therapeutic programs in healthcare is not without its risks. Chiropractic adjustments can result in adverse effects such as discomfort, pain, and soreness. In rare cases with underlying physical defects, deformities or pathologies may be at risk or prone to injury. It is the responsibility of the patient to make it known, or to learn through health care procedures if he or she is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Chiropractor. The Doctor of Chiropractic will not give any treatment or care if he or she is aware that such care should not be provided for a particular condition or circumstance.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic Care on this basis.

SIGNATURE

By signing below, I acknowledge that I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection as well as use of this information to this office of Precision Chiropractic & Wellness and agree to all terms above. I understand that I have the right to refuse to sign this authorization, and if I choose to, this practice has the right to refuse to give care and will not treat me. I agree that a photocopy of this form is to be considered as valid as the original and is valid indefinitely as a patient on record with Precision Chiropractic & Wellness or until further notified of any updates or terminations.

Signature: _____ **Date:** _____ / _____ / _____