PREGNANCY – NEW PATIENT

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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:** _______ **y.o.** **SSN:** __ __ __ __ __ __ __ __ __

Sex: MALE / FEMALE **Height:** _____ ft. _____ in. **Weight:** ________ lbs.

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: ☐ Text Message Alerts ☐ I Decline receiving Alerts

How did you hear about PCW? ____

Do we have your permission to use your first name to thank who referred you? ☐YES ☐NO

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

Emergency Contact Full Name: ______________________________ **Relationship:** ________________

DOB: _____ / _____ / ________ **Age:** _______ **y.o.** **Phone: (** _ _ _ **) -** _ _ _ **-** _ _ _ _

Emergency Contact Full Name: ______________________________ **Relationship:** ________________

DOB: _____ / _____ / ________ **Age:** _______ **y.o.** **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

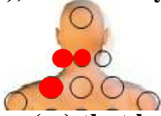
Is this Complaint a: ☐Auto-Accident ☐Work-Related Injury ☐Personal-Injury Claim **Date of Incident:** _____ / _____ / ______

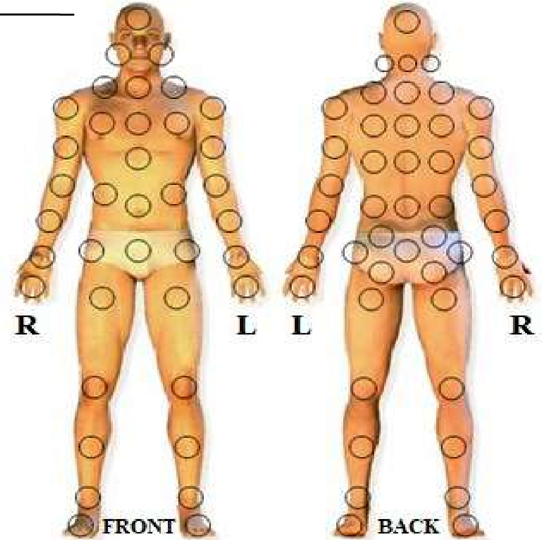
Describe your Primary Complaint: ____

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

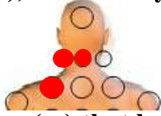
Is this Complaint a: ☐Auto-Accident ☐Work-Related Injury ☐Personal-Injury Claim **Date of Incident:** _____ / _____ / ______

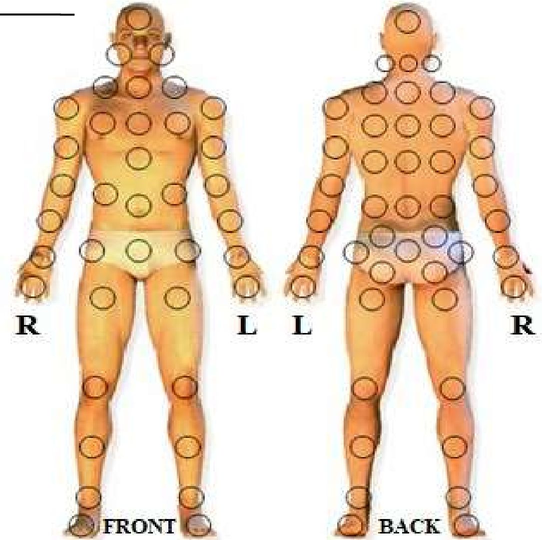
Describe your Primary Complaint: ____

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

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:** ______ / ______ / ____________

THIRD COMPLAINT – Please describe ONLY your 3rd Complaint Below

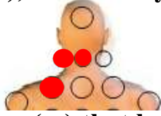
Is this Complaint a: ☐Auto-Accident ☐Work-Related Injury ☐Personal-Injury Claim **Date of Incident:** _____ / _____ / ______

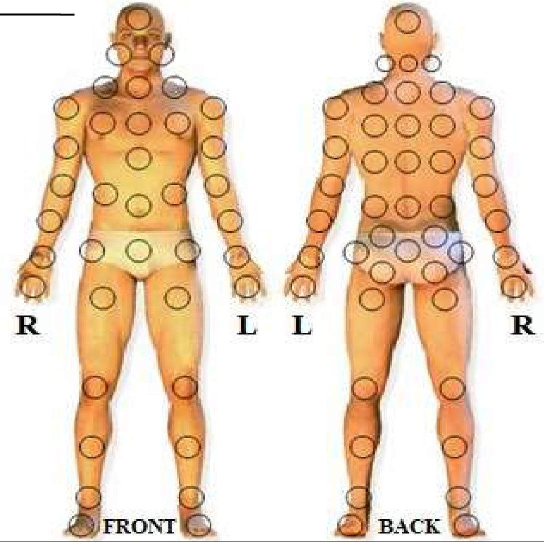
Describe your Primary Complaint: ____

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

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:** ______ / ______ / ____________

FOURTH COMPLAINT – Please describe ONLY your 4th Complaint Below

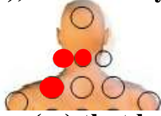
Is this Complaint a: ☐Auto-Accident ☐Work-Related Injury ☐Personal-Injury Claim **Date of Incident:** _____ / _____ / ______

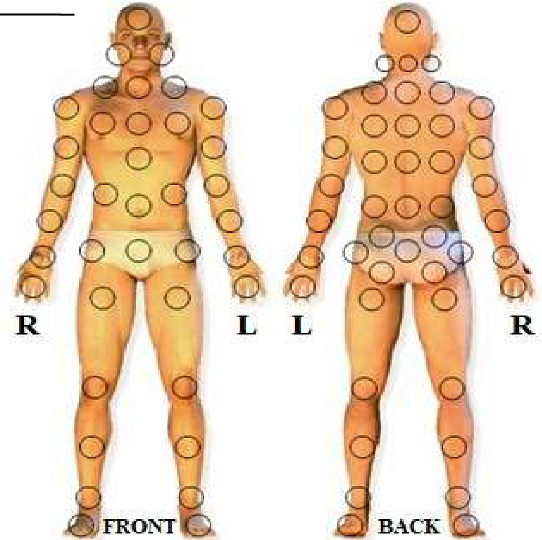
Describe your Primary Complaint: ____

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

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:** ______ / ______ / ___________

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

PAST PREGNANCY HISTORY – Please explain all of your previous pregnancies, labors and birthing experiences.

Is this your first pregnancy? ☐ YES ☐ NO **If NO, what number is your current pregnancy?** ________

Have you experienced any Infertility Issues or Miscarriages? ☐ YES ☐ NO **If YES, please describe:** __________________

____

3rd Trimester Presentation(s): ☐ Vertex ☐ Breech ☐ Transverse ☐ Headfirst

Location of Birth(s): ☐ Home ☐ Birthing Center ☐ Hospital

Type of Birth(s):
☐ Normal Vaginal ☐ Planned Caesarian Section ☐ Vacuum
☐ Induced Vaginal ☐ Emergency Caesarian Section ☐ Suction Cap
☐ Epidural Vaginal ☐ Forceps ☐ Water

Problems during Labor / Delivery:
☐ Antibiotics ☐ Excessive Bleeding ☐ Failure to Thrive ☐ Meconium
☐ Fetal Distress ☐ Perinatal Asphyxia ☐ Uterine Rupture ☐ Malposition
☐ Other(s): ____

Were any of your children born with any Genetic Disorders &/or Disabilities? ____

____

Were any of your children born with any Congenital Anomalies &/or Defects? ____

____

Were any of your children born the following Skin Colors at birth? ☐ Jaundice (Yellowing) ☐ Cyanosis (Blue Color)

CURRENT PREGNANCY

Current Trimester, Week, and your Expected Due Date? ____ Trimester ____ Week Expected Date: ____ / ____ / _______

Who is your Birth Attendant & their Name?
☐ Medical Doctor: ______________________________________
☐ Midwife: ______________________________________
☐ Doula: ______________________________________
☐ Other: ______________________________________

Dietary Habits during Pregnancy:
☐ Homemade Meals – From Scratch ☐ Homemade Meals – Store Bought
☐ Fast Food(s) ☐ Processed Food(s)
☐ Dietary Food(s) ☐ Solid Foods – Store Bought
☐ Other(s): ______________________________________

Number of Hours SLEEPING at NIGHT on average? ________ **Quality of Sleep?** ☐ Good ☐ Fair ☐ Poor

Any difficulties during this pregnancy? You may have only experienced this once or temporarily, but please report all that you have experienced.

☐ Nausea ☐ Multiple Gestation ☐ Gestational Diabetes ☐ Morning Sickness
☐ Cramps ☐ Pre-Eclampsia ☐ Rh Incompatibility ☐ Sleep Disturbance
☐ High BP ☐ Hemorrhoids ☐ Urinary Incontinence ☐ Urinary Infection
☐ Low BP ☐ Vomiting ☐ Bleeding / Spotting ☐ Bowel Problems
☐ Anemia ☐ Heartburn ☐ Depression ☐ STI’s
☐ Headaches ☐ Preterm Labor ☐ Flu Infection(s) ☐ Hair / Skin Issues

LABOR / DELIVERY – Most Recent Birth				
3rd Trimester Presentation:	☐ Vertex	☐ Breech	☐ Transverse	☐ Headfirst
Location of Birth:	☐ Home	☐ Birthing Center		☐ Hospital
Type of Birth:	☐ Normal Vaginal ☐ Induced Vaginal ☐ Epidural Vaginal	☐ Planned Caesarian Section ☐ Emergency Caesarian Section ☐ Forceps		☐ Vacuum ☐ Suction Cap ☐ Water
Problems during Labor / Delivery:	☐ Antibiotics ☐ Fetal Distress ☐ Other(s): ______	☐ Excessive Bleeding ☐ Perinatal Asphyxia	☐ Failure to Thrive ☐ Uterine Rupture	☐ Meconium ☐ Malposition
What Interventions were performed?	☐ Medication ☐ Pitocin ☐ Narcotics ☐ Oxygen	☐ Strep B Medication ☐ Stiches ☐ IV Port ☐ Ointment in the Eyes		☐ Hepatitis B ☐ Vitamin K Shot ☐ Glucose ☐ Episiotomy

Was your child born with any Genetic Disorders &/or Disabilities? ______________________________

Was your child born with any Congenital Anomalies &/or Defects? ______________________________

Birth Weight: __________ ounces **Birth Length:** __________ inches

AGAR Scores: __________ at Birth __________ at time of Existing Birth Center or Hospital

Was the Child's Skin Color EITHER of the following at birth? ☐ Jaundice (Yellowing) ☐ Cyanosis (Blue Color)

POSTPARTUM

Did you spend any extended period required in a hospital? ☐YES ☐NO If Yes, why? ______________________________

How soon after birth did the baby first nurse? ______________________________

Were there any issues with nursing/latching? ______________________________

How is your child currently feeding?

☐ Breast Feeding ☐ Bottle – Pumped Breast Milk
☐ Bottle – Store Bought Formula ☐ Bottle – Prescribed Formula
☐ Bottle – Homemade Formula ☐ Other: __________

How long is your Child SLEEPING at NIGHT on average? ________ hours **Quality of Sleep?** ☐ Good ☐ Fair ☐ Poor

How many NAPS do they take in a day? ________________ **What is your Quality of Sleep?** ☐ Good ☐ Fair ☐ Poor

Have you experienced any New Symptoms following the birth?				
	☐ Depression	☐ Lack of Energy	☐ Loss of Bladder Control	☐ Trouble Breathing
	☐ Headaches	☐ Hemorrhages	☐ Loss of Bowel Control	☐ Digestive Issues
	☐ Infections	☐ Blood Clots	☐ Vaginal Bleeding	☐ Anemia

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	☐	☐	☐	☐	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	HYPERthyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	HYPOthyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	Lupus	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	MS	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐	Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	Rheumatoid Arth.	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐	☐	Shingles	☐	☐	☐	☐	☐	☐	☐	☐
GERD	☐	☐	☐	☐	☐	☐	☐	☐	Skin Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐	☐

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
☐	☐	Fevers &/or Chills
☐	☐	Trouble Getting to Sleep
☐	☐	Trouble Staying Asleep
☐	☐	Fatigue
☐	☐	Weakness / Lack of Strength
☐	☐	Low Energy
☐	☐	Unexplained Weight Loss
☐	☐	Unexplained Weight Gain
☐	☐	Skin Rashes (such as Eczema)
☐	☐	Skin Dryness
☐	☐	Skin Color Changes
☐	☐	Sores &/or Ulcers
☐	☐	Hair & Nail Changes
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Head Injury
☐	☐	Struck Unconscious
☐	☐	Earache(s)
☐	☐	Hearing Loss &/or Difficulty Hearing
☐	☐	Ear Drainage
☐	☐	Ringing in the Ears (Tinnitus)
☐	☐	Eye Pain &/or Pressure
☐	☐	Blurry Vision
☐	☐	Double Vision
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Redness of the Eyes
☐	☐	Vision Loss
☐	☐	Seasonal Allergies
☐	☐	Sinus Infection(s)
☐	☐	Sinus Pressure &/or Pain
☐	☐	Hay Fever
☐	☐	Discharge from Nose
☐	☐	Loss of Smell
☐	☐	Thrush – Oral Fungal Infection(s)
☐	☐	Difficulty Swallowing
☐	☐	Loss of Taste
☐	☐	Swollen Tongue
☐	☐	Dry Mouth
☐	☐	Breast Lumps – Male & Female
☐	☐	Breast Pain – Male & Female
☐	☐	Nipple Discharge – Male & Female
☐	☐	Breast Cancer – Male & Female
☐	☐	Mastectomy – Male & Female
☐	☐	Breast Feeding Currently – Female Only
☐	☐	Breast Feeding Difficulties – Female Only

Current	Past	Symptom / Condition
☐	☐	Dry Cough
☐	☐	Productive Cough
☐	☐	Wet Cough
☐	☐	Coughing Up Blood
☐	☐	Shortness of Breath
☐	☐	Fast Breathing
☐	☐	Painful Breathing
☐	☐	Chest Pain
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Orthostatic Hypotension
☐	☐	Difficulty Breathing Lying Down
☐	☐	Palpitations ("Heart Skipping a Beat")
☐	☐	Awake from Sleep with Shortness of Breath
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Change in Bowel Habits
☐	☐	Vomiting
☐	☐	Change in Appetite
☐	☐	Heartburn, With Acidic Foods
☐	☐	Heartburn, With Fatty Foods
☐	☐	Heartburn, In-Between Meals
☐	☐	Heartburn, 30 minutes to 1 hour after Eating
☐	☐	Heartburn, When Lying Down
☐	☐	Rectal Bleeding / Blood When Whipping
☐	☐	Sudden Urgency to Urinate
☐	☐	Loss of Bladder Control
☐	☐	Frequent Urination
☐	☐	Blood in Urine
☐	☐	Kidney Stone(s)
☐	☐	Bladder Infection(s)
☐	☐	Candida or other Fungal Infection(s)
☐	☐	Genital Sores – Male & Female
☐	☐	STD's – Male & Female
☐	☐	Pain with Sex – Male & Female
☐	☐	Testicle Pain – Male Only
☐	☐	Testicle Masses or Lumps – Male Only
☐	☐	Erectile Dysfunction – Male Only
☐	☐	Genital Discharge – Male & Female
☐	☐	Leg Cramps, During Day
☐	☐	Leg Cramps, Wake You At Night
☐	☐	Calf Pain with Walking
☐	☐	Calf Pain with Stairs
☐	☐	Swelling in Calves
☐	☐	Swelling in Ankles
☐	☐	Swelling in Feet

HEALTH CHECKLIST – CONTINUED

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

STRESS ASSESSMENT

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