MONARCH
FAMILY CHIROPRACTIC

ABOUT THE PATIENT

Name: _____ **Today's Date:** ___/_____/_____ **Birth Date**: ___/___/_____ **Age:** _____

Gender: □ Male □ Female **Pronoun**: _____ **Marital Status:** □Single □Married □Widowed □Divorced □Other_____

Significant Other's Name: _____**Children's Names & Ages:** _____

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

Phone: Cell & Carrier (for text reminder purposes): _____

Home: _____ **Work:** _____

E-Mail Address: _____ **Who may we thank for referring you?** _____

Employer: _____ **Type of Work:** _____

Emergency Contact: _____ **Their Phone #:** _____

Name of Medical Doctor(s): _____

Have you been to a Chiropractor before? □ Yes □ No **Last visit to a chiropractor**:_____

Chiropractic techniques you've had success with: _____

Method of payment for first visit: □ Cash □ Check □ Credit Card □ HSA/FSA

CURRENT HEALTH PROFILE

What brings you into our office? Please briefly describe your chief concern**, including the impact it has had on your life**. If you have no symptoms or concerns right now skip to the General History Section.

Health Concerns:	Severity: 1=Minimal 10=Extreme	When did this start?:	Are the symptoms constant or intermittent?	Did the problem begin with an injury?:

Have you had same or similar problem(s) before? □ Yes □ No **How long?** _____

Father/Mother/Brother/Sister/Children with similar problems? _____

Other doctors who have treated this problem? _____

_____

Surgery you've had: _____

Medication(s) you take: _____

What have you heard about chiropractic? _____

Do you know what a subluxation is? If yes, please describe: _____

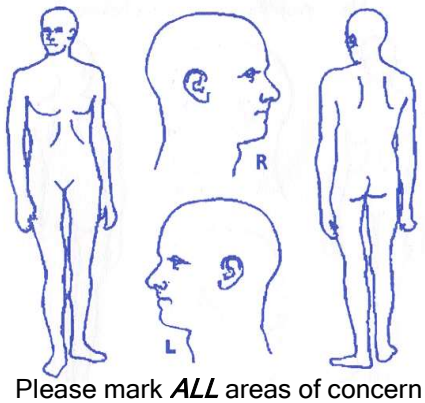
_____

What daily rituals for spinal health do you presently practice?

_____

Are you pregnant?

□ Yes □ No □ Unknown



Please mark ***ALL*** areas of concern

MONARCH
FAMILY CHIROPRACTIC

GENERAL HEALTH HISTORY

Since the Nervous System controls everything in your body, it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. **Please check the following symptoms that apply to your health:**

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Arthritis
❑	❑	Allergies	❑	❑	Tobacco Use
❑	❑	Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Disorders
❑	❑	Hands or Feet Cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Heartburn
❑	❑	Difficulty Concentrating	❑	❑	Indigestion
❑	❑	Vision Problems	❑	❑	Fatigue
❑	❑	Balance Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Frequent Colds	❑	❑	Menstrual Pain / Cramping
❑	❑	Dizziness or Lightheadedness	❑	❑	Constipation / Loose Stools
❑	❑	Bronchitis / Pneumonia	❑	❑	Fertility Problems
❑	❑	Hernia	❑	❑	Herniated Disc
❑	❑	Other _____			

Favorite Hobbies/Interests: _____

Consent for Consultation/Examination & Newsletter

Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

I also authorize Monarch Family Chiropractic to send educational material, via newsletter, to my given email address with the knowledge that I may opt out at any time.

Name: _____ **Date:**_____

Signature:_____ **Witness:**_____

Doctor of Chiropractic: *Dr. Kristen Zawada* | *Dr. Miaken Zeigler*