ABOUT THE PATIENT

Potent Chiropractic

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I authorize Potent Chiropractic LLC to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long-term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

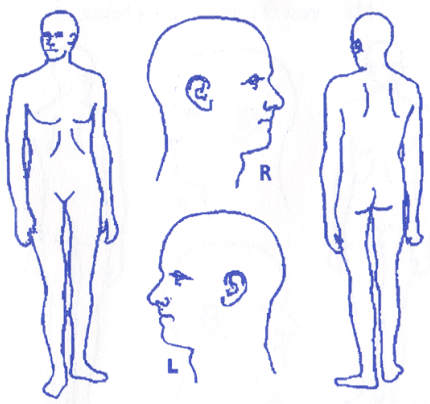
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Potent Chiropractic

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. **List any medications being taken:**_____
2. **Number of courses of Antibiotics child has taken in the last 6 mo.**_____ **Total during lifetime**_____
3. **Name of Pediatrician and Other Doctors:** _____
4. **Date of Last Visit** _____/_____/_____ **Reason:**_____
5. **Name of Obstetrician/Midwife:**_____
6. **Location of Birth:** ❑ **Hospital** ❑ **Birthing Center** ❑ **Home**
7. **Complications During Pregnancy:** ❑ **No** ❑ **Yes Explain:**_____
8. **Ultrasounds During Pregnancy:** ❑ **No** ❑ **Yes How Many:**_____
9. **Medication During Pregnancy / Delivery** ❑ **No** ❑ **Yes List:**_____
10. **Cigarette / Alcohol Use during Pregnancy:** ❑ **No** ❑ **Yes**
11. **Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":** ❑ No ❑ Yes, Name_____

PAST HISTORY

12. **List any past auto collisions:**_____ **Was any care received?**_____
13. **List any past falls bumps bruises:** _____ **Was any care received?**_____
14. **List any past sport, recreational, or home injuries:**_____
15. **Please describe any past conditions and treatment received:** _____

_____

16. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

OFFICE POLICY

Potent Chiropractic LLC

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially to see if their spine is developing abnormally. A spinal check–up is easy and fun for kids.

WE ALSO OFFER:

- Intersegmental traction, ice packs, and spinal orthotics.
  Please ask if you have any questions about these services!

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great! ☺

OFFICE VISITS MAY INCLUDE:

- **Specific Chiropractic Adjustments** to promote mobility, stimulate tissue, enhance alignment. This is when the Doctor works directly on your neck or back, sometimes making a popping sound. $50 - $65
- **Extremity Adjustments** to promote mobility, stimulate tissue, enhance alignment of extremity joints. $25
- **Intersegmental / Mechanical traction** to tense / relax soft tissues, aid healing and mobility. This is the black table with the rollers that effectively extend, stretch, and traction the spine. $45
- **Heat** for sub-acute or chronic conditions. The digital heat pack used on the area of concern. $10
- **Cold** to reduce swelling, this is the ice pack used on the area of concern. $10
- **Therapeutic Exercises** to improve spinal flexibility, strength and motion. These are stretches or exercises that you perform or the Doctor administers to you. Excellent for the neck, mid, and lower back. $45 per unit
- **Neuro Muscular Re-Education** to develop and improve coordination and balance, as well as promote flexibility and strength. An example is the Wobble chair the Doctor has you exercise with. $45 per unit
- **Home** and / or **Work** Activity of Daily Living Counseling $50
- **Supports/Pillow/Braces** if needed and as priced.

Patient: _____ Date _____ Staff_____