Snyder Family Chiropractic - 1003 Egypt Rd. Bldg A, Phoenixville, PA - (610) 935-5900

Welcome to our Chiropractic Office. Please take a moment to fill out this CONFIDENTIAL information.

Name (First,Last): _____ *Evaluation* Date ____/___/_____

Age _____ Gender M / F Birth Date _____/_____/_____ Social Security Number _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

E-Mail: _____ (used only for occasional communications)

Home Phone (_____) _____-_____ ☐ Work / ☐ Mobile Phone (____)_____-_____

Best contact method?_____

Mailing Address _____

City _____ State _____ Zip_____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who referred you to our practice? _____

Your prior Chiropractor's name and address: _____

Last date you went to a Chiropractor: *Last date*_____ *Past results* ☐ Great ☐ Good ☐ Fair ☐ Mixed ☐ Poor

General Medical Practitioner: _____Phone _____

Address _____ City_____ State____ Zip_____

Your Occupation: _____

Your Employer: _____Phone number: _____ City _____

Spouse's name: _____ Spouse's employer:_____

Children's names & ages: _____

Method of Payment for today ☐ Cash, ☐ Check, ☐ Credit Card

☐ I also would like to use a third party insurance benefit to cover part of my care.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's (or Guardian) Signature: _____ Date: ___/___/___

(On behalf of _____)

★★★ Why this information is important ★★★

We focus on your ability to be healthy, not just symptom free. Our goals are *first*, to address the underlying cause of that which brought you to this office, and *second*, to offer you the opportunity of maintaining health for the future. Each day, we express *physical, chemical, and emotional* stresses that can accumulate and result in serious loss of health potential. Most time the effects are gradual; not even felt until they become serious. Answering the following questions will give us profiles of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

I. Symptoms or Wellness

If you have no symptoms or complaints, and are here for wellness services, please check here _____ "Wish to have Chiropractic Wellness Services" and skip this page. Otherwise, please briefly describe the chief area of complaint, including the effect it had on your life.

1. PRIMARY CHALLENGE: _____

a. Is this health challenge due to any of the following: Car Accident - On the Job - Slip & Fall – Sports - Household

b. How often do you experience these symptoms? □ Infrequent □ Occasional □ Intermittent □ Frequent □ Constant

c. Type of Pain: □ Sharp □ Dull □ Stabbing □ Achy □ Radiating □ Burning □ Weakness □ Numbness □ Tingling □ Stiffness

d. PAIN INTENSITY: Circle the number best describing the intensity of your pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

e. Who else have you seen for this challenge? _____

f. How long have you been suffering with this health challenge? _____days / weeks / months / years / too long to recall

Have you had this problem before? If YES, when? _____

h. What makes the symptoms Increase? _____Decrease? _____

i. How does this symptom affect your daily life? (circle all that apply) Minimally – Slightly – Moderately - Severely

k. How important is it to you to find the cause of this problem: **Little importance** 1 2 3 4 5 6 7 8 9 10 **Very important**

2. SECOND CHALLENGE: _____

a. Is this health challenge due to any of the following: Car Accident - On the Job - Slip & Fall – Sports - Household

b. How often do you experience these symptoms? □ Infrequent □ Occasional □ Intermittent □ Frequent □ Constant

c. Type of Pain: □ Sharp □ Dull □ Stabbing □ Achy □ Radiating □ Burning □ Weakness □ Numbness □ Tingling □ Stiffness

d. PAIN INTENSITY: Circle the number best describing the intensity of your pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

e. Who else have you seen for this challenge? _____

f. How long have you been suffering with this health challenge? _____days / weeks / months / years / too long to recall

Have you had this problem before? If YES, when? _____

h. What makes the symptoms Increase? _____Decrease? _____

i. How does this symptom affect your daily life? (circle all that apply) Minimally – Slightly – Moderately - Severely

k. How important is it to you to find the cause of this problem: **Little importance** 1 2 3 4 5 6 7 8 9 10 **Very important**

1a. How important is your overall Quality of Life to you? **□ Not Important □ Somewhat □ Very □ Most Important**

II. **Present and Past Personal Health Profile**

1. Indicate your current: Height ___ft ____in **Weight** _____pounds

2. Please rate your overall Health. □ Excellent □ Very Good □ Good □ Fair □ Poor

A. Do you feel you are healthier then you were 5 years ago? □ **Yes** □ **No**

B. Do you believe your health will improve in the next 5 years? □ **Yes** □ **No**

C. What are you doing currently, or you wish to do, to improve your health over the next 5 years? _____

_____

3. What level of exercise do you do? □ Strenuous □ Moderate □ Light □ None

4. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS □ Other: _____

5. List all prescription and over the counter medications you are currently taking:

_____

6. List all of the nutritional supplements you are currently taking:

_____

7. List all surgical procedures you ever had (even as a child):

_____

8. What activities do you do most of your day?

1. □ **Sit:** □ Most of the day □ Half the day □ A little of the day
2. □ **Stand:** □ Most of the day □ Half the day □ A little of the day
3. □ **Computer work:** □ Most of the day □ Half the day □ A little of the day
4. □ **On the phone:** □ Most of the day □ Half the day □ A little of the day
5. □ **Travel Frequently**
6. □ **Manual Labor**

9. What Physical Activities or hobbies do you engage in outside of work? (CIRCLE the one you do to reduce stress)

_____

10. Have you ever been hospitalized? □ No □ Yes (why) _____

11. Past Trauma: Research is showing that many of the health challenges that occur later in life, have their origins during the developmental years, some starting at birth. **Have you had any of these significant past traumas?**

	YES/	NO/	UNSURE	DESCRIBE
1. Did you have any serious **falls**?	□	□	□	_____
2. Did or do you play **sports**?	□	□	□	_____
3. Did you take / use any **illicit drugs**? (*Confidential*)	□	□	□	_____
4. Have you **fallen** / **jumped** from a height over 3 feet?	□	□	□	_____
5. Were you involved in any **motor vehicle accidents**?	□	□	□	_____
6. Prolonged use of **medicine** (antibiotics, inhaler)?	□	□	□	_____
7. Did you suffer any **physical or emotional trauma**?	□	□	□	_____

13. Do you consume: 1. □ Alcohol 2. □ Caffeine Products 3. □ Tobacco 4. □ Recreational Drugs
5. □ Tap Water 6. □ Artificial Sweeteners 7. □ Refined Sugars 8. □ Other_____

14. Each of the following stresses is a potential cause for emotional stress on the body. Please note their severity on a 0-3 scale.
(0=no stress, 1= mild, 2= moderate, 3= severe stress)

1. □ Childhood____ 2. □ Loss of a loved one_____ 3. □ Recreational Activities_____ 4. □ Family_____
5. □ Work/School ____ 6. □ Stress of Illness_____ 7. □ Relationships_____ 8. □ Commuting_____
9. □ Personal Divorce____ 10. □ Parent's Divorce_____ 11. □ Finances_____ 12. □ Lifestyle Change _____

15. OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS SERIOUS HEALTH CONCERNS:

Past	Present		Past	Present		Past	Present	
□	□	**Headaches**	□	□	**High Blood Pressure**	□	□	**Diabetes**
□	□	**Neck Pain**	□	□	**Heart Attack**	□	□	**Excessive Thirst**
□	□	**Upper Back Pain**	□	□	**Chest Pains**	□	□	**Frequent Urination**
□	□	**Mid Back Pain**	□	□	**Stroke**	□	□	**Smoking/Tobacco Use**
□	□	**Low Back Pain**	□	□	**Angina**	□	□	**Drug/Alcohol Dependance**
□	□	**Shoulder Pain**	□	□	**Kidney Stones**	□	□	**Allergies**
□	□	**Elbow/Upper Arm Pain**	□	□	**Kidney Disorders**	□	□	**Depression**
□	□	**Wrist Pain**	□	□	**Bladder Infection**	□	□	**Systemic Lupus**
□	□	**Hand Pain**	□	□	**Painful Urination**	□	□	**Epilepsy**
□	□	**Hip Pain**	□	□	**Loss of Bladder Control**	□	□	**Dermatitis/Eczema/Rash**
□	□	**Upper Leg Pain**	□	□	**Prostate Problems**	□	□	**HIV/AIDS**
□	□	**Knee Pain**	□	□	**Abnormal Weight Gain/Loss**			
□	□	**Ankle/Foot Pain**	□	□	**Loss of Appetite**	**For Females Only**		
□	□	**Jaw Pain**	□	□	**Abdominal Pain**	□	□	**Birth Control Pills**
□	□	**Joint Pain/Stiffness**	□	□	**Ulcer**	□	□	**Hormonal Replacement**
□	□	**Arthritis**	□	□	**Hepatitis**	□	□	**Pregnancy**
□	□	**Rheumatoid Arthritis**	□	□	**Liver/Gall Bladder Disorder**			
□	□	**Cancer**	□	□	**General Fatigue**			
□	□	**Tumor**	□	□	**Muscular Incoordination**			
□	□	**Asthma**	□	□	**Visual Disturbances**			
□	□	**Chronic Sinusitis**	□	□	**Dizziness**			
□	□	**Other:**_____						

I . If our chiropractic wellness center could assist you to attain optimal health through a multi-facet approach to wellness, would you be interested in talking to us about this? □ **YES** □ **YES, but not right now.** □ **NO**

J. Is there anything else you think we should know about you?

_____

_____