Personal Information

Please Print and fill out all information

Name: _____ Date of Birth_____

Address: _____ City: _____ State: ____ Zip code: _____

Home Phone: _____ Work: _____ Cell Phone: _____

E-mail address: _____ Who referred you to our office? _____

Marital Status: Single/Mar/Div./ Widow(er) Spouse's Name: _____#of Children _____

Employer: _____Job Duties_____

Personal and Family Health History

Do you have a family Doctor? ☐ No ☐ Yes Name of Doctor: _____

Date of last visit: _____ Date of last exam: _____

Have you ever been to a Chiropractor? ☐ No ☐ Yes Name of Chiropractor _____

Date of last Adjustment: _____ What type of problem were you experiencing? _____

Have you had surgery in the past 5 years? ☐ No ☐Yes Date of most recent surgery: _____

Other Surgery: (please list): _____

Please list medications you are currently taking _____

Do you currently take nutritional supplements? Please list? _____

How many ounces of water do you currently drink each day? _____

Present Illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Social History:

Alcohol? ☐ No ☐ Yes
Drinks per week?

Cigarettes? ☐ No ☐ Yes
Packs per day?
Former smoker? ___

Caffeine? ☐ No ☐ Yes
Drinks per day?

Exercise? ☐ No ☐ Yes Hours per week? _____
(circle one) Light / Moderate / Strenuous

CURRENT HEALTH CONCERNS

Please indicate the current areas that you are experiencing difficulties by marking on the picture below. Please provide details of each concern by answering the questions that follow.

Briefly describe your main reason for seeking Chiropractic care.

_____

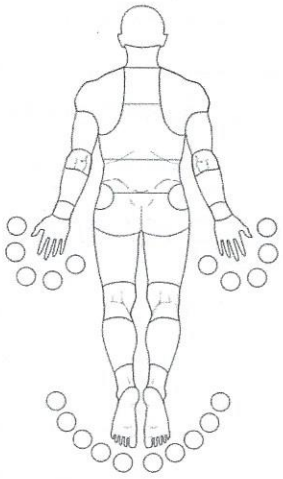
_____

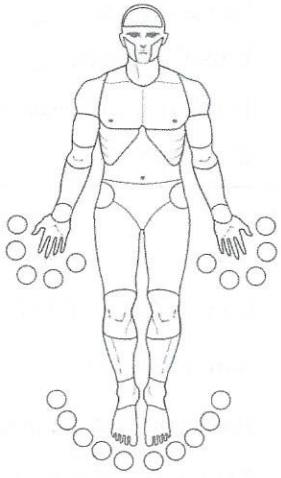
Please list other health concerns.

_____

_____

_____





Area of Concern _____

Rate the Severity of the pain. Mild Mild to moderate Moderate Moderate to severe Severe

On a scale of 0-10, what is your level of pain No pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating

How often does the pain occur? ☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%

How long have you been dealing with this problem? _____Have you seen other doctors for this problem? YES NO

Please list _____

What makes it better? ☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing

What makes it worse? ☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ looking down

☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth

☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving

☐ Housework ☐ Bright lights ☐ Loud Noises

Please describe the pain. ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Electric shock ☐ Fiery ☐ Shooting

☐ Superficial ☐ Deep

Does the pain radiate to other parts of your body? YES NO If yes, please list the location. _____

When is the pain at it's worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night Activities: ☐ Light ☐ Moderate

Other symptoms that are associated with this problem. ☐ Dizziness ☐ Nausea ☐ Visual Problems

☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance

Signature:_____ Date_____

TERMS OF ACCEPTANCE

Dr. Walter Piekarczyk
Chiropractic Family Center

When a person seeks chiropractic care in our office, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal and it's important to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: Is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

We do not offer to treat any disease or condition other than **Vertebral Subluxation**. However, if during the course of a chiropractic spinal examination or your daily visits, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. OUR ONLY PRACTICE OBJECTIVE is to determine the presence or absence of **Vertebral Subluxation** and correct it via Specific Chiropractic Adjustments.

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 date