MODERN CHIROPRACTIC CENTER

Thank you for scheduling your initial appointment with us. We look forward to helping you achieve your health care goals!

Please arrive 15 minutes prior to your appointment, with your completed paperwork, so that we can get you checked in. Please be sure you are not wearing any metal, such as zippers or buttons as it will interfere with the x-rays. We have athletic clothing for you to change into, or you can wear / bring your own.

You will receive a reminder call the day before your appointment, but please give us the courtesy of calling if you need to reschedule your appointment before then.

We are located at 8505 W. Overland Rd. Boise, ID 83709, on the South side of Overland between Cole Rd and Maple Grove. (next to West Side Pizza and ATA Martial Arts). Please feel free to call or email us with any questions prior to your appointment at (208) 629-1904 or info@ModernChiropracticCenter.com. We look forward to seeing you soon!

Yours in Ideal Health,

The team at Modern Chiropractic Center

Full Name: _____ Nickname: _____ Age: ___ Gender: [ ] M [ ] F

Home Street Address: _____ Home Phone: (____) _____

City, State, Zip: _____ Work Phone: (____) _____

Email Address: _____ Mobile Phone: (____) _____

Birth Date: ____/_____/_____ Social Security #: _____- _____- _____ Marital Status: S M D W

Height_____ Weight_____ Race/Ethnicity: [ ] African American [ ] Arabic [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native Am.

Primary Spoken Language: _____ How were you referred to this office? _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Spouse Work Phone: (___) _____ Spouse Mobile: (___) _____

Spouse's Employer: _____ Occupation: _____

PURPOSE OF VISIT

Reasons for appointment:	Date condition started:	Have you had this before?	Injury related?
1._____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
2._____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
3._____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No

EXPERIENCE WITH STANDARD CHIROPRACTIC

Have you seen a Chiropractor before? [ ] Yes [ ] No Who? _____

When? _____ Reason for visits? _____

How did you respond? _____

Did your previous chiropractor take before and after **X-rays**? [ ] Yes [ ] No

Did your previous chiropractor tell you that **poor posture** can negatively affect your overall health? [ ] Yes [ ] No

Did your previous chiropractor make you aware of any of your **poor posture habits**? [ ] Yes [ ] No

Explain: _____

Are you aware of any poor posture habits in your **spouse or children**? [ ] Yes [ ] No

Explain: _____

OTHER PROVIDERS

Medical Doctors Seen:

Name: _____ Date of last visit: _____ Is this your primary care provider? [ ] Yes [ ]No
Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Name: _____ Date of last visit: _____ Is this your primary care provider? [ ] Yes [ ]No
Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Name: _____ Date of last visit: _____ Is this your primary care provider? [ ] Yes [ ]No
Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Previous surgeries (all types) and dates: _____

What other testing or treatments have you tried to date for **present condition** with location (facility) and dates of those tests and treatments: _____

Patient's Initials: _____

Current over-the-counter medications: _____

_____

Current prescription medications: _____

_____

SOCIAL HISTORY AND LIFESTYLE

Do you exercise? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? [ ]Running [ ]Jogging [ ]Weight Training [ ]Cycling [ ]Yoga [ ]Pilates [ ]Swimming [ ] Other _____

Do you consider yourself to be? [ ] Underweight [ ] Normal weight [ ] Overweight [ ] Obese [ ] Severely obese

Do you smoke? [ ] Yes [ ] No How much? _____

Do you drink alcohol? [ ] Yes [ ] No How much? _____ per [ ] day [ ]week [ ] Month [ ] Year

Do you drink coffee? [ ] Yes [ ] No How many cups per day? _____

What supplements do you take (i.e. vitamins, minerals, herbs)? _____

FAMILY HEALTH HISTORY

Have any of your **biological family members** ever been diagnosed with the following:

[ ] Mental Health Disease	[ ] Neurological Problems	[ ] Lung Disease	[ ] Thyroid	[ ] Arthritis
[ ] Circulatory Problems	[ ] Immune System Problems	[ ] Heart Murmur	[ ] Back Pain	[ ] Cancer
[ ] High Blood Pressure	[ ] Heart Disease	[ ] Epilepsy	[ ] Stroke	[ ] Diabetes
[ ] Kidney Disease	[ ] Epilepsy/Seizures	[ ] Migraine Headaches	[ ] Osteoporosis	[ ] Scoliosis
[ ] Liver Disease	[ ] Infectious Disease	[ ] Gall Bladder	[ ] Broken Bones/Fractures	
[ ] Autoimmune Disorders	[ ] Digestive Disorders	[ ] Other: _____		

_____

Family History	**Present Age(s)**	**Age(s) at Death**	**Medical Problems / Cause(s) of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

☐ Please check here if you were adopted and this does not apply to you.

IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Work Phone (____) _____ Home Phone (____) _____ Cell Phone (____) _____

FOR OFFICE USE ONLY

Patient's Health Conditions Acceptable for Chiropractic BioPhysics® Corrective Care? [ ] YES [ ] NO [ ] Referred out: _____

Doctor's Signature: _____ *Date:* _____

NEW PATIENT— Patient's Name:_____
HISTORY OF PRIMARY COMPLAINTS Date:_____

Is this the first time you have had this pain? [ ] Yes [ ] No If No, when was the FIRST time you had these same symptoms? _____
How did the CURRENT episode of pain/discomfort occur?_____

_____

How did the FIRST episode of pain/discomfort occur?_____

_____

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain Location:_____	Pain Location_____	Pain Location:_____	Pain Location:_____
RIGHT NOW: _____/ 10	RIGHT NOW: _____/ 10	RIGHT NOW: _____/ 10	RIGHT NOW: ____ /10
At its WORST: _____/ 10	At its WORST: _____/ 10	At its WORST: _____/ 10	At its WORST: ____ / 10
At its BEST: _____/ 10	At its BEST: _____/ 10	At its BEST: _____/ 10	At its BEST: ____ / 10
At its AVERAGE: _____/ 10	At its AVERAGE: _____/ 10	At its AVERAGE: _____/ 10	At its AVERAGE: ____ / 10

What makes your pain DIMINISH? (check all that apply):
[ ] Nothing [ ] Ice [ ] Heat [ ] Massage/Rubbing [ ] Exercise/Activity [ ] Sitting
[ ] Standing [ ] Rest [ ] Stretching [ ] "Popping" the joints [ ] Bracing/taping [ ] Laying
[ ] Other: _____
[ ] Over-The-Counter Medications:_____
[ ] Prescription Medications: _____

What makes your pain WORSE? (check all that apply):
[ ] Coughing [ ] Sneezing [ ] Bearing Down [ ] Sexual Intercourse [ ] Running [ ] Standing
[ ] Lifting [ ] Bending [ ] Pushing [ ] Pulling [ ] Driving [ ] Sitting
[ ] Walking [ ] Laying down [ ] Movement of the head [ ] Movement of the low back
Other:_____

Would you describe your pain as:
Location:_____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
Location:_____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
Location:_____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom

Pain Quality: How would you describe your pain/discomfort (check all that apply):
[ ] Dull [ ] Achy [ ] Stiff [ ] Intense [ ] Throbbing [ ] Sharp [ ] Sharp with movement
[ ] Stabbing [ ] Shooting [ ] Burning [ ] Constricting [ ] Annoying [ ] Tight [ ] Unbearable
Other: _____

Radiating: Does your pain seem to radiate from the primary area: [ ] Yes [ ] No If Yes, where does the pain radiate to? _

_____

Numbness/Tingling (pins and needles): Do you experience or have you recently experienced numbness and or tingling anywhere? [ ] No [ ] Yes: Please describe where and when you feel these symptoms: _____

_____

Is your pain/discomfort WORSE:
[ ] In the morning
[ ] In the afternoon
[ ] In the evening
[ ] While sleeping
[ ] While awake
[ ] It does not seem to be affected by the time of day

Is your pain/discomfort BETTER:
[ ] In the morning
[ ] In the afternoon
[ ] In the evening
[ ] While sleeping
[ ] While awake
[ ] It does not seem to be affected by the time of day