

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email\* \_\_\_\_\_ Phone- HM \_\_\_\_\_ WK \_\_\_\_\_ Cell \_\_\_\_\_  
 \* Your email will NOT be shared with any third party, and is used for occasional office announcements and promotions # Children \_\_\_\_\_  
 Best Number To Reach You \_\_\_HM \_\_\_WK \_\_\_CELL Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_Married \_\_\_Single \_\_\_Divorced \_\_\_Widowed Emergency Contact \_\_\_\_\_ Tel \_\_\_\_\_  
 SS# \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

REFERRED BY \_\_\_Met the Doctor \_\_\_Website \_\_\_Online Search - please list keywords used to find us \_\_\_\_\_  
 \_\_\_Sign/Location \_\_\_Newspaper \_\_\_Other \_\_\_\_\_  
 Existing Patient \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Attorney \_\_\_\_\_

**Insurance Information**

Name of party responsible for payment \_\_\_\_\_ Phone \_\_\_\_\_ Do you have health insurance? \_\_\_ Name of company \_\_\_\_\_

**\* If an auto accident, please provide:**

Insurance Company Name \_\_\_\_\_ Contact Person Phone: \_\_\_\_\_ Claim # \_\_\_\_\_

**Signatures**

Name of the insured \_\_\_\_\_  
 I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.  
 Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
 Spouse's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

**IF YOU NEED MORE ROOM TO ANSWER ANY QUESTION, PLEASE USE THE BACK OF THIS FORM.**

**What is your major complaint?** (include Left, Right, or Bilateral) \_\_\_\_\_

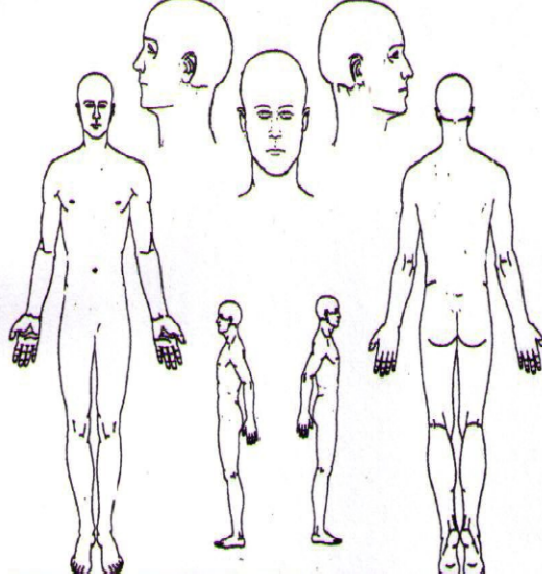
Does it radiate anywhere? \_\_\_Y \_\_\_N If yes, where? \_\_\_\_\_  
 How long have you had this complaint? \_\_\_\_\_ days / weeks / months / years Have you had this or a similar condition in the past? \_\_\_Y \_\_\_N  
 Is this condition progressively getting worse? \_\_\_Y \_\_\_N \_\_\_Staying the same Is it: \_\_\_Constant \_\_\_Frequent \_\_\_Comes and Goes  
 Circle all that apply: Achy, Dull, Throbbing, Crushing, Sharp, Severe, Stabbing, Burning, Other \_\_\_\_\_  
 With 0 = no pain, and 10 = severe, at its best, my pain is a: 0 1 2 3 4 5 6 7 8 9 10 - At its worst, my pain is a 0 1 2 3 4 5 6 7 8 9 10

CIRCLE: This is a NEW / OLD injury and WAS / WAS NOT treated before. If treated before, what was done? \_\_\_\_\_

We attempt to update your other health care providers regarding your condition unless you specifically request that we do not.  
 Name and Clinic of your other Doctor(s) \_\_\_\_\_

Have you ever had Chiropractic care before? \_\_\_Y \_\_\_N Date of last visit \_\_\_\_\_ Other complaints? (If you need more space, please write on the back of this form): \_\_\_\_\_

**Please mark each area of pain / complaint with:**  
 N= Numbness T = Tingling B = Burning  
 S = Stiffness D = Dull Pain S = Sharp Pain



**Please mark each condition with a "C" for Current, and a "P" for past, AND RATE on a scale of 1-10, with 0 = pain / severity and 10 = extreme pain / severity. Example: C-6 for Current, 6/10 pain. If Left or Right Please circle L or R**

- |                                  |                                            |                        |
|----------------------------------|--------------------------------------------|------------------------|
| _____ Neck Problems              | _____ Sore Muscles                         | _____ Allergies        |
| _____ Shoulder Problems- L or R  | _____ Muscle Cramps                        | _____ Hay Fever        |
| _____ Arm Problems L or R        | _____ Broken Bones                         | _____ Asthma           |
| _____ Numbness L or R Arm        | _____ Frequent Colds                       | _____ Eczema           |
| _____ Numbness L or R Leg        | _____ Headaches/Migraines                  | _____ Menstrual Cramps |
| _____ Low Back problems          | _____ Ear Infections                       | _____ Diabetes         |
| _____ Leg Problems L or R        | _____ Dizziness                            | _____ Poor Digestion   |
| _____ Pain b/t shoulders         | _____ Fainting                             | _____ Diarrhea         |
| _____ Pain in Joints             | _____ Forgetfulness                        | _____ Constipation     |
| _____ Loss of Feeling            | _____ Depression                           | _____ Chest Pain       |
| _____ Restricts Daily Activities | _____ Blurred Vision                       | _____ Pain at Night    |
| _____ Restricts Exercise         | _____ Difficulty Breathing                 | _____ Blood Pressure   |
| _____ Unwanted Weight Gain       | _____ Ringing in Ears                      | _____ Circle: High/Low |
| _____ Unexplained Weight Loss    | _____ Difficulty Walking                   | _____ Bowel / Bladder  |
| _____ Unusual Fatigue            | _____ Difficulty Speaking                  | _____ difficulties     |
| _____ Nausea / Vomiting          | _____ Numbness on one side of face or body |                        |
| _____ Difficulty Swallowing      | _____ Neck or Head Pain like never before  |                        |
| _____ Other                      |                                            |                        |

**Family Health History:** Please list any condition (Ex: heart disease, cancer, diabetes, arthritis, ect.) that your father, mother, spouse, brothers, sisters, or children have, or have had in the past:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Last time you had Spine X-rays \_\_\_\_\_

Medications and Supplements you now take \_\_\_\_\_

From past to present, please list by date and describe

1. Car Accidents \_\_\_\_\_

Any known allergies to Medications / Supplements?     Y    N  
(If yes, please explain) \_\_\_\_\_

2. Falls / Injuries (Including Sports) / Work trauma (with date of trauma) / Fractures (including date)

List all surgeries you've had (with date of surgery) \_\_\_\_\_

**Please rate how your pain / symptoms / health problems affect your Activities of Daily Living. Rate on a scale of 1-10, with 0 = No Problem to do / participate in the Activity, and 10 = extreme pain or problems doing the activity. If an Activity of Daily Living category does not apply to you, please leave it blank.**

- |                    |                                   |                           |                 |
|--------------------|-----------------------------------|---------------------------|-----------------|
| _____ Bending      | _____ Carrying                    | _____ Concentrating       | _____ Dancing   |
| _____ Doing Chores | _____ Doing Computer Work         | _____ Dressing Driving    | _____ Gardening |
| _____ Lifting      | _____ Performing Sexual Activity  | _____ Playing Sports      | _____ Pushing   |
| _____ Reading      | _____ Recreating                  | _____ Rolling Over        | _____ Running   |
| _____ Shoveling    | _____ Sitting to Standing         | _____ Sitting             | _____ Sleeping  |
| _____ Standing     | _____ Walking                     | _____ Watching TV         | _____ Working   |
| _____ Climbing     | _____ Playing with kids/grandkids | _____ Other (please list) |                 |

**As a Wellness Office, it is our desire to help you improve every aspect of your life as it relates to your health.**

How would you rate your diet?     Poor     Fair     Good     Excellent

How would you rate your exercise?     Poor     Fair     Good     Excellent

Please rate your stress levels on a scale of 1 to 10 with 1 = low and 10 = high     Personal Stress     Job Stress     Other stress

Habits	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Is there anything else you want the doctor to know?     Y     N If yes, please state it here:

\_\_\_\_\_

\*The following information is true and accurate to the best of my knowledge.\* **X** \_\_\_\_\_

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