Medina
FAMILY CHIROPRACTIC
& ACUPUNCTURE

Welcome to
Medina Family Chiropractic and Acupuncture

Please let us know if you have any questions

First Name:	MI	Last Name:

Preferred Name:

Phone Number:

Street Address:		City:
	State:	Zip:

Social Security #:

Email:

Birthdate:	Marital status:
Occupation:	Employer:

How were you referred to us?

Emergency Contact Name:	Phone #:
	Relation:

Primary Care Physician:

May we contact your primary care physician? Yes No

Insurance information:

Insurance carrier:		
Name of policy holder:		**DOB of policy holder:**
Relationship of policy holder to you:	Self Child	Spouse
Secondary insurance if any:		

Authorization and release: I authorize payment of insurance benefits directly to Medina Family Chiropractic if applicable. I authorize Dr. Martin or Dr. Hobbs to release all information necessary to communicate with personal physicians and other health care providers and payers to secure payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Patient's Name (printed): _____

Signature: _____ Date: _____

Guardian's Signature if applicable: _____

Chief Complaint:

Where is your pain?	Low back Neck	Other: _____
When did your symptoms begin? (circle one)	Today This week 3-6 months ago 6mo-1 year	Within last three months More than 1 year ago
What describes the frequency of your discomfort?	Constant Frequent	Intermittent Occasional
What describes the changes in your discomfort during the day?	Worse in the morning Changes with weather	Worse in the afternoon Worse at night It does not change
What helps relieve your discomfort?	Ice Heat	Medication Other: _____
What activities are limited by your discomfort?	Bending Bowel Movements Coughing Daily Routine Driving Getting up Lifting Lying down Pulling Pushing	Reading Sitting Sleeping Sneezing Standing Turning my head Urination Walking Working Other: _____
What does the discomfort feel like? (sharp, dull, achy)		
Does the discomfort radiate to other areas?	No	Yes, please describe:
How would you rate your discomfort?	0 1 2 3 4 5 No pain	6 7 8 9 10 Excruciating pain

Social History:

Do you smoke?	Never smoker	
	Former smoker	
	Current smoker	How much?
Do you drink alcohol?	No	Yes, amount?

Women's Health History:

Are you pregnant?	No	Yes EDD:

Medical History:

Have you ever been diagnosed with cancer?	No	Yes, please describe:
Have you ever been diagnosed with an emotional/mental condition?	No	Yes, please describe:
Please list any falls, accidents, or fractures with dates if applicable:		
Please list any surgeries with dates if applicable:		
Please list any current medications:		

Please circle if you have ever experienced the following conditions:

Arthritis	Herniated Disc	Muscular Dystrophy
Gout	TMJ Dysfunction	Parkinson's Disease
Numbness in hands or feet	Multiple sclerosis	Polio
Osteoporosis	Sciatica	Pinched Nerve
Blindness	Meniere's disease	Eczema
Cataracts	Rhinitis	Psoriasis
Deafness/hearing loss	Tinnitus	Sinusitis
Glaucoma	Ear ringing	Vertigo
Anemia	Emphysema	Lupus
Hemophilia	Other lung disorder	Rheumatoid Arthritis
Hepatitis	Raynaud's Phenomenon	Autoimmune Disorder
Hypotension	Sickle Cell Anemia	Scleroderma
Asthma	Chronic Sinus Infections	Epilepsy
HIV/AIDS	Chronic Fatigue Syndrome	Crohn's disease
Headaches	Gallbladder problems	Kidney Disease
Diabetes	Irritable Bowel Syndrome	Liver Disease
Seizures	Thyroid Dysfunction	Unexplained Weight Loss
Infertility	Prostate Enlargement	Menopause
Uterine Fibroids	Cystitis	Chronic Yeast Infections

Do you have a history of stroke or hypertension?	No	Yes
Do you have a pacemaker?	No	Yes
Do you have a congenital condition?	No	Yes, please describe:
Do you have any allergies?	No	Yes, please describe:

Please list immediate family health history:

Condition:	Family Member:
Condition:	Family Member:
Family history is unknown: _____	

I certify the information provided is accurate to the best of my knowledge:

Name (printed): _____ Date: _____

Signature: _____

Guardian signature (if applicable): _____

Media Release Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Medina Family Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability: I understand that I may revoke this authorization at any time in writing.

Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

Name (printed): _____ Date: _____

Signature: _____

Guardian signature (if applicable): _____