SCHILBACH CHIROPRACTIC
UPPER CERVICAL SPECIALIST

Name:_____ Today's Date:_____

Address:_____City: _____ State: ___ Zip: _____

Cell Phone:_____ Work Phone:_____E-mail:_____

Birth Date: _____ Your SS#: _____

Marital Status: M S W D Referred by:_____

Your Employer: _____ Occupation: _____ Years on Job: _____

Work Address: _____City: _____ State: ___ Zip: _____

Please Check Type of Payment: □Cash □Check □MasterCard/Visa

Do you have Health Insurance? □Yes □No Note: We do not bill insurance, but can provide a Superbill.

Do You Have Medicare/Medicaid? □Yes □No Note: We do not bill Medicare or Medicaid.

Name of Emergency contact:_____ Phone: _____

Is Your Condition Due To An Accident? □Yes □No Date of Accident: _____

Type of Accident? □Auto □Work/Job □At Home □Other:_____

I (we) agree to pay for services rendered to the above mentioned patient due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date:_____

Guardian's Signature (For Minors):_____Date:_____

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What are your Current Health Problems that bring you to this office:_____
_____
_____
List Any Traumas (accidents and surgeries) and their Dates:_____
_____
_____
What Medications and Vitamins are you taking:_____
_____
_____
What Other Doctors have you seen, Treatments And Results Obtained?_____
_____
What do you do for work?:_____
_____
List Current Physical Activities/Frequency per week:_____
_____
What are your Passions in Life?_____
What are Stressors in Life?_____
Briefly describe your diet (bfast, lunch, dinner, snack)_____
_____

Please Check The Conditions You Have or Have Had:

( ) AIDS	( ) Diabetes	( ) Polio
( ) Anemia	( ) Epilepsy	( ) Rheumatic fever
( ) Arthritis	( ) Fibromyalgia	( ) Rheumatoid arthritis
( ) Cancer	( ) Hypoglycemia	( ) Tuberculosis
( ) Fatigue	( ) Multiple sclerosis	( ) Muscle weakness
( ) Depression	( ) Parkinson's disease	Other:
CARDIOVASCULAR	VERTEBROBASILAR	**VERTEBROBASILAR**
( ) General swelling	( ) Loss of coordination	( ) Inability to form words
( ) Swelling in legs/face/eyes	( ) Loss of memory	( ) Previous head injury
( ) Chest pain	( ) Ringing in ears	( ) Dizziness/ Loss of Balance
( ) Pounding heart beat	( ) High Cholesterol	( ) Fainting
( ) Heart attack	( ) High blood pressure	( ) Stroke or Family history of stroke

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Head	Neck	Mid-Back
( ) Headaches (Severe/Light)	( ) Pain/ muscle spasm	( ) Pain/ muscle spasm Indicate where:_____
( ) Vertigo/Dizziness	( ) Stiffness/ Limited movement	( ) Stiffness/ Limited movement
( ) Loss of taste/smell/hearing	( ) Grinding/popping	( ) Dull ache
Shoulders	*Arms & Hands*	*Low-Back*
( ) Pain/ muscle spasm Indicate where:_____	( ) Pain/ muscle spasm Indicate where:_____	( ) Pain/ muscle spasm Indicate where:_____
( ) Can't raise arm	( ) Numbness/ Fingers go to sleep	( ) Stiffness/ Limited movement
	( ) □Cold/ □Swollen hands	( ) Dull ache
Hips, Legs, Feet	Skin, Hair, Nails	Eyes
( ) Pain/ muscle spasm Indicate where:_____	( ) Dry, itchy, rough or scaly skin ( ) Oily skin ( ) Yellow skin	( ) Wear glasses ( ) Blindness ( ) Light sensitive
( ) Pins and needles	( ) Bruise easily	( ) Blurred or double vision
( ) Numbness	( ) Nail biting	( ) Eye fatigue
( ) Cold/swollen feet or ankles	( ) Hair loss (□ eyebrows)	( ) Excessive/ Lack of tearing
Ears	Nose & Sinus	Mouth & Throat
( ) Loss of hearing	( ) Nose bleeds	( ) Pain in throat
( ) Pain in ears	( ) Pressure over eyes	( ) Bleeding gums
( ) Discharge from ears	( ) Frequent colds	( ) Tooth abscess
( ) Ringing in ears	( ) Allergies	( ) Difficulty swallowing
Respiratory	Gastrointestinal	Gastrointestinal
( ) □Shortness of breath/□Wheezing	( ) Poor appetite ( ) Constantly hungry ( ) Indigestion	( ) Constipation ( ) Diarrhea (□blood/ □mucous)
( ) Dry cough ( ) Productive cough (□blood)	( ) Nausea & vomiting ( ) Abdominal pain	( ) Urination (□frequent/ □infrequent) ( ) Pain (□blood/ □cloudy)

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Women Only	Social History	Social History Con't
( ) Taking birth control pills ( ) Premenstrual Syndrome	( ) Smoke (□ other than tobacco)	( ) Feeling "run-down"
( ) Lumps in breast ( ) Spotting/ Vaginal discharge	( ) Alcohol. What/How much per week? _____	( ) Nervousness ( ) Irritability ( ) Panic attacks
( ) Painful periods ( ) Irregular periods	( ) Drink □ Coffee □Tea How much? _____	Family Stress? □Yes □No □High/ □Moderate/ □Minimal
# of pregnancies _____ # of deliveries _____	Hours of sleep? _____ Restful? □Yes □No	Job Stress? □Yes □No □High/ □Moderate/ □Minimal

X-Ray Consent

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.
I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests and x-rays.

_____
Patient Signature and Date

_____
Witness Signature and Date

FEMALES ONLY:
I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in anyway.

_____
Patient Signature and Date

_____
Witness Signature and Date