WELCOME TO ABUNDANT HEALTH CHIROPRACTIC

How did you hear about us? [ ] Walk/Drive by [ ] Referred - If so, by who:_____
[ ] Other:_____

PATIENT INFORMATION

Name: _____ Age: ____ Today's Date: _____
Last First Middle

Address: _____
City State Zip

Primary Phone: _____ Other Phone: _____ Sex: M ____ F ____

DOB: _____ SSN: _____ E-mail: _____

[ ] Single [ ] Married, Spouse's Name: _____ [ ] Divorced [ ] Widowed No. of children: _____

Occupation: _____ Employer: _____

Employment Status *(check one)*❑ Employed ❑ Student ❑ Other ❑ Retired ❑ Self Employed

Employer's Address: _____ Employer's Phone: _____

Primary Care Physician:_____Phone:_____

Race *(check all that apply))*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian/ Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other____❑ I choose not to specify

EMERGENCY CONTACTS

Name: _____ Relationship: _____
Home: _____ Work: _____ ext. _____ Cell: _____

Exercise:	Work Activities:	Hobbies/Interests:	Habits:
[ ] None [ ] Moderate [ ] Heavy [ ] Daily	[ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor	_____ _____ _____ _____	[ ] Smoking Cigarettes/Day ___ [ ] Alcohol Drinks/Week ___ [ ] Caffeinated drinks: Drinks/Week ____ [ ] High Stress Level: Reason _____

On a scale of Poor, Good, or Excellent, describe your: Diet _____ Exercise _____
Sleep _____ General Health _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10(very interested)

Current medications: Including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.

If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No

If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑Yes ❑No ❑ Not Sure

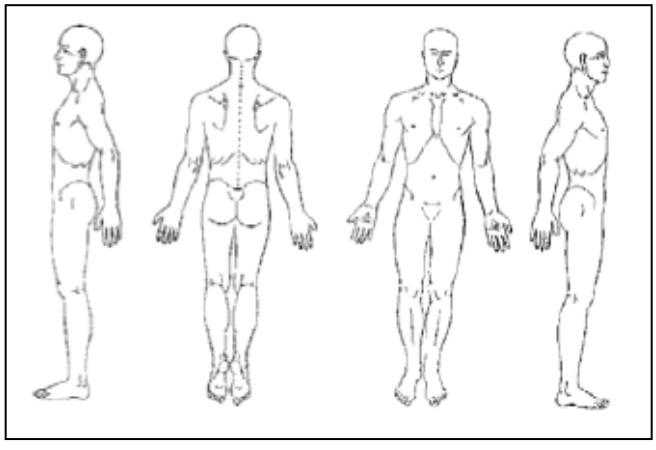
If yes, other comments regarding Diabetes: _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you are here for wellness services and have no symptoms or complaints, please check here _____ and skip this portion. Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

Using the adjacent body charts, please circle all affected areas and label with the following:

- Pain (circle all areas of pain)
- Numbness (mark with / / / /)
- Tingling (mark with "X")



LEFT BACK FRONT RIGHT

Briefly describe what you have been experiencing:

_____
_____
_____
_____
_____
_____
_____

If you are experiencing pain, is it… (check all that apply):

[ ] Sharp [ ] Dull [ ] Comes & Goes [ ] Travels [ ] Constant

Since the problem started, it is…

[ ] About the Same [ ] Getting Better [ ] Getting Worse

What makes it worse:_____

It interferes with:[ ] Work [ ] Sleep [ ] Walking [ ] Sitting [ ] Hobbies [ ] Leisure [ ] Other: _____

Other Doctors seen for this problem (please list):
[ ] Chiropractor: _____ [ ] Medical Doctor: _____
[ ] Other: _____

List any past serious accidents with dates:

_____

_____

Are you pregnant or nursing? [ ] Yes [ ] No

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

[ ] Headache [ ] Neck Pain [ ] Stiffness [ ] Constipation [ ] Sensitive Eyes [ ] Menstrual Pain [ ] Loss of Memory [ ] Hot Flashes [ ] Heartburn	[ ] Upset Stomach [ ] Fatigue [ ] Fever [ ] Sleep Problems [ ] Irritability [ ] Mood Swings [ ] Numbness in Toes	[ ] Short Breath [ ] Tension [ ] Diarrhea [ ] Loss of Balance [ ] Mood changes [ ] Cold Feet [ ] Depression [ ] Nervousness	[ ] Loss of Smell [ ] Loss of Strength [ ] Loss or change of Taste [ ] Loss of coordination [ ] Fainting [ ] Stiff Neck [ ] Ulcers	[ ] Dizziness [ ] Ears ring [ ] Nausea [ ] Cold Hands [ ] Cold Sweats [ ] Problem Urinating [ ] Menstrual Irregularity

Vitals: B/P:____/_____ Weight:_____ Height:_____

ACCOUNT RESPONSIBILITY (Who is responsible for this account?)
[ ] Self [ ] Family Member [ ] Other: _____
Method of Payment: [ ] Cash [ ] Check [ ] Credit Card [ ] Credit Care [ ] Insurance
Insurance Company: _____ Policy/ID#:_____
Insured's Name: _____ Insurance Phone:_____
Claim#: _____

I, the undersigned, certify that I (or my dependent) have insurance with the above carrier and assign directly to Dr. Sutton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party's Signature: _____ Date:_____

Please bring your Insurance Card and I.D. to the front desk to make copies for our records.