Topsail CHIROPRACTIC
17230 US HWY 17 North Suite #108
Hampstead NC, 28443

ABOUT THE PATIENT

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____
Address _____ **City** _____ **State** _____ **Zip** _____
Home Phone _____ **Cell Phone** _____ **Work Phone** _____**Gender** _____
Significant Other's Name _____ **Kid's Names and Ages** _____
Your Employer _____ **Type of Work** _____
Email Address _____ **Have you been to a chiropractor before?** □ **No** □ **Yes**
Emergency Contact _____ **Phone** _____
Name of Medical Doctor(s)_____

- **I authorize the doctor or their staff to render care as deemed appropriate for me and/or my child.**
- **I authorize Topsail Chiropractic to release and/or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **I authorize assignment of my insurance benefits (if applicable) directly to the provider.**
- **Person responsible for this account if other than the patient?** _____
- **I understand that after any initial promotional services all care is rendered at usual and customary fees.**
- **For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.**

_____ _____
Patient / Parent Signature **(This represents a long term authorization for all occasions of service)** **Date**

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ **How long has this been an issue?** _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same
❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

2. _____ **How long has this been an issue?** _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same
❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

3. _____ **How long has this been an issue?** _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same
❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

4. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

5. What makes it better? 1._____ **2.**_____
3._____

6. What makes it worse? 1. _____ **2.**_____
3._____

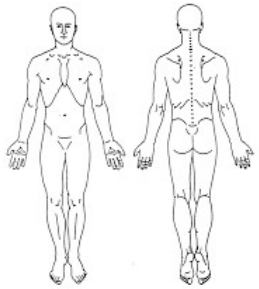
7. What Doctor's have you seen for this? _____
_____

8. Type of treatment:_____

9. Results: _____

NOTES: _____
_____

Please mark all areas of concern.



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GENERAL HEALTH HISTORY

Patient Name_____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. **List any medications being taken:**_____
2. **Name of Pediatrician and Other Doctors:** _____
3. **Date of Last Visit to Medical Doctor ____/____/____ Reason:**_____
4. **Name of Obstetrician/Midwife:**_____
5. **Location of Birth:** ❑ **Hospital** ❑ **Birthing Center** ❑ **Home**
6. **Complications During Pregnancy:** ❑ **No** ❑ **Yes Explain**:_____
7. **Cigarette / Alcohol Use during Pregnancy:** ❑ **No** ❑ **Yes**
8. **Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor."**

❑ No ❑ Yes, Name_____

PAST HISTORY

9. **List any past auto collisions:**_____ **Was any care received?**_____
10. **List any past falls bumps bruises**_____ **Was any care received?**_____
11. **List any past sport, recreational, or home injuries:**_____
12. **Please describe any past conditions and treatment received:** _____

_____

13. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side:□ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Mother's side:□ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Is there any other family history you want us to know?_____