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._____

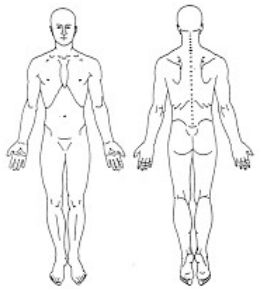
6. What makes it worse? 1. _____ **2.**_____
3._____

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

8. Type of treatment:_____
9. Results: _____
NOTES: _____
_____

Are you pregnant?
❑ Yes ❑ No

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	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other_____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing:_____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes

If yes please list their name:_____

_____

PAST HISTORY

4. List any past auto collisions:_____ **Was any care received?** _____

5. List any past work injuries: _____ **Was any care received?**_____

6. List any past sport, recreational, or home injuries_____

7. Please describe any past conditions and treatment received: _____

_____

8. 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? _____