Mr. \ Mrs. \ Ms. \ Miss

First Name: _____ M.I.:____ Last Name: _____

What Do You Prefer To Be Called: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SS #: _____ Sex: _____ Single \ Married \ Divorced \ Widow

Spouse Name: _____ Email: _____

Home #: _____ Cell #: _____ Other #: _____

Emergency Contact: _____ Relationship: _____ T: _____

How did you hear about us? _____

Who can we thank for the referral? _____

Who is your Primary Care Doctor? _____

Do you have Medicare? ☐ Yes ☐ No

Primary Insurance: _____

Secondary Insurance: _____

POLICY

Legacy Clinic utilizes an outside billing service. **You will be responsible for the cost of the initial exam ($99 for exam without X-rays - $175 for Exam with X-rays).** You may be asked to pay for additional services in advance but any reimbursement received will be credited to your account or refunded to you. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Legacy Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions. I acknowledge that we have provided you this information and accept responsibility for payments due to Legacy Clinic.

_____ _____ _____

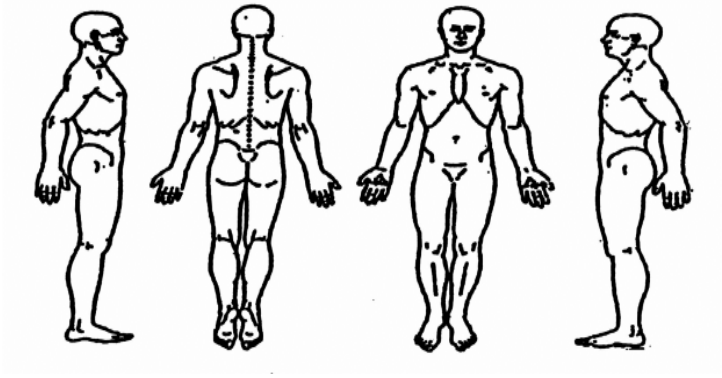
Signature Date Parent (if patient is a minor)

Describe your PRIMARY symptoms: _____
List other symptoms: _____

Have you had any x-rays\MRIs\CTs taken that are related to your symptoms? ☐ Yes ☐ No

Where: _____

Indicate on the drawings below where you have pain/symptoms:



How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?
☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy
☐ Burning ☐ Shooting ☐ Stiff ☐ Sharp w/ Motion ☐ Shooting w/ Motion
☐ Stabbing w/ Motion ☐ Electric like ☐ Other: _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0 – 10 (10 being the worst), how would you rate your symptom?
0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

Who else have you seen for these symptoms?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Orthopedist ☐ Physical Therapist
☐ Other: _____

How long have you had these symptoms? _____

How\When do you think your symptoms began? _____

Do you consider your symptoms to be severe? ☐ Yes ☐ Yes, at times ☐ No

What aggravates your symptoms? _____

What alleviates your symptoms? _____

What concerns you the most about your symptoms\ what do they prevent you from doing?

_____

What is your: **Height**: _____ **Weight**: _____ **Blood Pressure:** _____

How would you rate your overall health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do?
☐ Strenuous ☐ Moderate ☐ Light ☐ None

SOCIAL HISTORY

1. **Smoking: → How often?** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. **Alcoholic Beverage: consumption occurs →** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. **Recreational Drug use:** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. **Extracurricular Activities**:_____

5. **Impact of Current Condition on Work Capacity:** ☐ No Effect ☐ Painful ☐ Limits ☐ Unable to work

What extracurricular activities do you participate in? _____

Indicate if you have any immediate family members with any of the following:

☐Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Cancer ☐ ALS ☐ Heart Problems

List all prescription medications you are currently taking: _____
_____

List all of the Supplements/Vitamins you are currently taking: _____
_____

List all surgical procedures you have had: _____
_____

Have you ever been hospitalized? □ No □ Yes
If yes, why_____

Have you ever significant past trauma? □ No □ Yes

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain				
		□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status

PRINT PATIENT NAME	SIGNATURE	DATE

INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that Dr. John C. Theeck will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Dr.'s of Legacy Clinic. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

PRINT PATIENT NAME	SIGNATURE	DATE

If patient is a minor:

PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)	Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

Name	Relationship
Name	Relationship