Welcome to Chiropractic Solutions

Patient #: _____ Date_____ Name: Last_____ First_____
Address_____ City_____ St_____ Zip_____
Home #_____ Work #_____ Cell #_____ # of Children: _____
Preferred #? H / W / C Sex M / F Date of Birth_____ Married / Single / Widow / Divorced
Student: Yes / No Military: Yes / No Email_____
Occupation_____ Employer_____

Whom may we thank for referring you to our office? _____

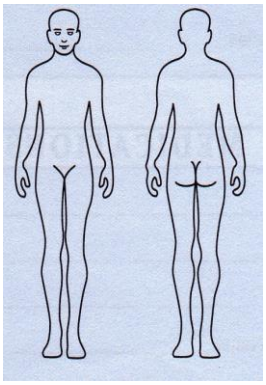
Emergency Contact_____ Relationship to patient _____
City of Residence_____ St_____ Zip_____ Contact Phone #_____

Your Health Profile

List your chief complaints in order of severity: Please Circle Frequency of Pain

1) _____Start Date? _____ Pain Level (1-9) _____ ≥25% 25% 50% 75% 100%
2) _____ Start Date? _____ Pain Level (1-9) _____ ≥25% 25% 50% 75% 100%
3) _____ Start Date? _____ Pain Level (1-9) _____ ≥25% 25% 50% 75% 100%

Please indicate areas with an 'x'.



List other doctors (medical, chiropractic, other) you have consulted for these conditions:

_____

Notice – Not all patients require X-Rays to determine or verify a diagnosis, type of treatment or length of treatment; if your exam warrants X-Ray analysis the following office policy prevails:

1) All first visit charges with or without X-Rays are payable when service is rendered.
2) The fee paid for X-Rays is for analysis only
3) The film itself is the property of this office and remains a part of your permanent records

List any over the counter and prescription medications you are taking:

Medication_____ Reason_____ How Long?_____
Medication_____ Reason_____ How Long?_____
Medication_____ Reason_____ How Long?_____

What kind of **vitamins/nutritional supplements** do you take?_____

Would you like to learn more about the Nutritional Response Testing that Dr. Kingston provides? Yes No

(Women Only) Are you pregnant? Yes No Breast Implants? Yes No
Breast Feeding? Yes No Birth Control? Yes No

Your Childhood Years

Did you have any serious falls as a child? Yes No Did you play youth sports? Yes No
Did you take any prescription medication? Yes No Were you under regular Chiropractic care? Yes No

Your Adult Years

Do/did you play sports? Yes No
What sports? _____

On a scale of 1-10 describe your stress level.
(1=none, 10=extreme) Occupational: ____ Personal: _____

Do/did you smoke? Yes No Packs per day? ____

Do you consume alcohol? Yes No Drinks per week?____

How heavy is your exercise? None Moderate Heavy
Number of times you exercise per week? _____

How many caffeinated beverages do you consume on a daily basis? _____ Carbonated beverages? _____

Please check all symptoms you have experienced in the last 6 months even if they do not seem to relate to your current problem.

__Allergies
__Asthma
__Cancer
__Constipation
__Depression
__Diabetes
__Diarrhea
__Dizziness
__Fainting
__Fatigue
__Frequent Urination
__Headache/Migraine
__Heartburn
__High Blood Pressure
__Hip Pain
__Indigestion/Gas
__Irregular Cycle
__Irritability
__Knee Pain
__Light Bothers Eyes
__Loss of Balance
__Loss of Memory
__Loss of Smell
__Loss of Taste
__Low Back Pain
__Menstrual Pain
__Mood Swings
__Neck Pain/Stiffness
__Nervousness
__Numbness in Fingers
__Pins & Needles in Arms/Hands
__Pins & Needles in Legs/Feet
__Poor Concentration
__Ringing in Ears
__Shortness of Breath
__Shoulder Pain
__Sinuses
__Sleeping Problems
__Sore Throat
__Stomach Upset
__Swollen Joints
__Tension/Anxiety
__Upper Back Pain
__Ulcers

Your Health GOALS

On a scale of 1 – 10, where would you place yourself at this time in your life?

SETTLER *"I'm Alive"*			**SURVIVALIST** *"I can live with this"*				**THRIVAL INSTINCT** *"I want to be the very best I can be"*			
0	1	2	3	4	5	6	7	8	9	10

How do you want us to address your problem or condition?

_____Temporary Relief (Help the symptom, but do not fix the cause of the problem.)
_____Correction (Correct the cause of the problem & minimize relapse in the future.)

On a scale of 1 – 10 (1 being the least and 10 being the most)

_____ How committed are you to being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature **Date**