Country – *Required*

United States

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

State – *Required*

Postal / Zip – *Required*

Date of Birth – *Required*

Gender

Refers to current gender which may be different than what is indicated on your insurance policies.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file.

Guardian

Emergency Contact – *Required*

Emergency Contact Phone – *Required*

Emergency Contact Relationship – *Required*

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of referring professional

Referring professional phone (if known)

Referring professional email (if known)

Occupation *– Required*

Employer

How did you hear about us?

How did you hear about us?

Who were you referred to?

Tillman Family Chiropractic

Section 2

Patient Health Questionaire

Welcome to Tillman Family Chiropractic!

Please answer each of these sections that are applicable to your health and discomfort status. You will be asked

about your Primary Complaint first (what you suffer from the most), then, if applicable, a Secondary complaint. Thank you!

1.) First/Primary/Major area of complaint- Only list the most bothersome here &please provide a brief description. (If there is more than one complaint, list it at the "Secondary Complaint" section) – *Required*

When did your pain or discomfort BEGIN? – *Required*

Date:

Rate your pain or discomfort on a scale from 0 to 10

0 - Being in no pain or discomfort	1	2 - Mild pain or discomfort	3	4	5 - Moderate pain or discomfort	6	7	8 - Severe pain or discomfort	9	10 - Highest level of pain or discomfort experienced

Pain or discomfort description – *Required*

- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Tension
- ☐ Stiffness
- ☐ Radiating Pain (into your head, arm, or leg)

What activites WORSEN this condition? – *Required*

☐ Sitting ☐ Standing ☐ Walking ☐ Lying down/sleeping ☐ Exercise ☐ Lifting/Carrying

☐ Traveling in car ☐ Working

What decreases your pain? – *Required*

☐ Nothing makes the pain better ☐ Ice/cold products ☐ Heat ☐ Rest ☐ Lying down/sleeping

☐ Massage ☐ O.T.C. Medications (Tylenol, Advil, Motrin, NSAIDS, Ibuprofen, Aleve, Aspirin)

☐ Prescription/Pain medications

2.) Secondary or other areas of complaint (please provide a brief description, if none, leave blank).

When did your pain or discomfort for this secondary complaint BEGIN?

Date:

Rate your pain or discomfort on a scale from 0 to 10

0 - Being in no pain or discomfort	1	2 - Mild pain or discomfort	3	4	5 - Moderate pain or discomfort	6	7	8 - Severe pain or discomfort	9	10 - Highest level of pain or discomfort experienced

Pain or discomfort description

☐ Aching

☐ Burning

☐ Dull

☐ Sharp

☐ Stabbing

☐ Throbbing

☐ Weakness

☐ Numbness/tingling

☐ Tension

☐ Stiffness

☐ Radiating Pain (into your head, arm, or leg)

What activities WORSEN this condition?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying down/sleeping ☐ Exercise ☐ Lifting/Carrying

☐ Traveling in car ☐ Working

What decreases your pain?

☐ Nothing makes it better ☐ Ice/cold products ☐ Heat ☐ Rest ☐ Lying down/sleeping ☐ Massage

☐ O.T.C. Medications (Tylenol, Advil, Motrin, NSAIDS, Ibuprofen, Aleve, Aspirin)

☐ Prescription/Pain medications

Check any Prior Treatments you have received for either of these complaints #1 and #2

☐ No other treatment ☐ Chiropractic care ☐ Surgery(s) ☐ Acupuncture/Dry Needling

☐ Massage therapy ☐ Physiotherapy ☐ Drugs/prescriptions

Goals or Reasons for seeking Chiropractic care?

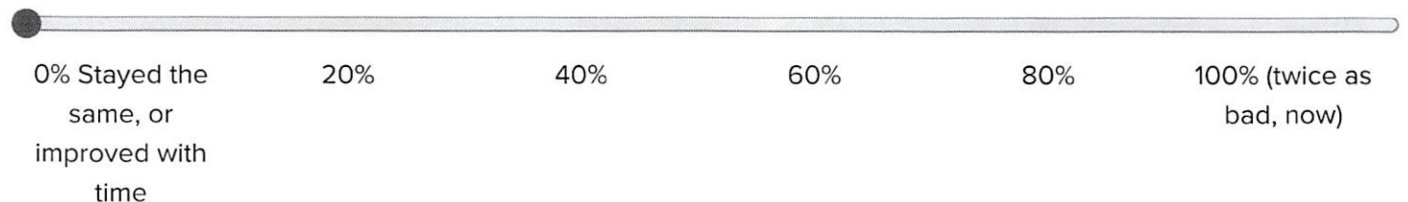
☐ Less Pain ☐ More Mobility ☐ Exercise with less pain ☐ Work with less pain ☐ Travel with less pain

☐ Sleep better ☐ Concentrate better

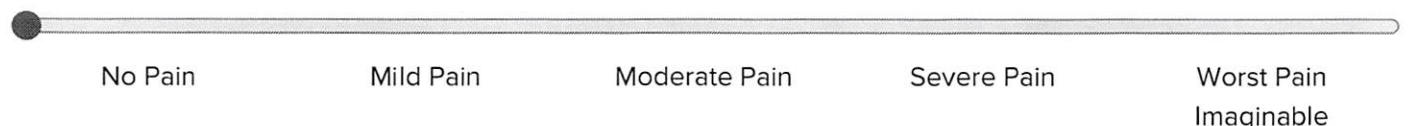
Were you recently or in the past injured at Work or in a Car Accident? (If so, please describe the incident)

Functional Rating Index Questions: Lets get to know how much your complaints bother you.

How much has your overall discomfort WORSENED with time?



Pain Intensity - How intense in your pain/discomfort?



Sleep and Resting

Perfect, undisturbed sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

Personal Care - How difficult is it to care for yourself?

No restrictions	Mild restrictions	Need to go slowly	Need "some" assistance	Need 100% assistance

Traveling (driving or riding in a car greater than 15 min)

No pain	Mild pain	Moderate pain	Severe pain	Cannot ride in a car at all

Work - normal/daily occupations

Can perform usual work	Can perform 75% of usual work	Can perform 50% of usual work	Can perform 25% of usual work	CANNOT work

Recreation - Fun activities, exercise, chores, yardwork, etc

Can do ALL activities	Can do Most activities	Can do Some activities	Can do Few activities	Cannot do ANY activities

Frequency of Pain (how often is your pain/discomfort?)

No pain	25% of the day	50% of the day	75% of the day	100% of the day - constantly in pain

Lifting/Carrying or Pushing/Pulling

No pain with heavy lifting	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with ANY weight

Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 minutes	Increased pain with ANY standing

Sitting

No pain	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 minutes	Increased pain with ANY sitting

Walking

No pain	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1 /4 mile	Increased pain with ALL walking

Your Health History Questionnaire (please check all current or previous conditions as they may apply)

General Sympotms – *Required*

- ☐ None
- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ History of Headaches
- ☐ History of Migraines
- ☐ Fever
- ☐ Excess Sweating
- ☐ Night Sweats
- ☐ Night Pain
- ☐ Generalized Pain
- ☐ Nervousness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Allergies

Neurological Symptoms – *Required*

☐ None ☐ Numbness or tingling ☐ Radiating pain ☐ Dizziness ☐ Fainting ☐ Problem Speaking ☐ Blurred Vision ☐ Nausea

Eyes / Ears / Nose / Throat Symptoms – *Required*

☐ None ☐ Hearing Loss ☐ Failing Vision ☐ Vision Problems ☐ Eye Pain ☐ Ringing / Buzzing in ears ☐ Other Hearing problems not otherwise listed

Respiratory Symptoms – *Required*

- [ ] None
- [ ] Asthma
- [ ] Chronic Cough
- [ ] Difficulty Breathing
- [ ] Shortness of breath
- [ ] Bronchitis
- [ ] Emphysema

Cardiovascular Symptoms – *Required*

- [ ] None
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Previous Stroke (or TIA)
- [ ] Cerebral (head) Vascular Aneurysm
- [ ] Hardening of Arteries
- [ ] Swelling of Ankles
- [ ] Poor Circulation
- [ ] Chest pains
- [ ] Congestive Heart Failure
- [ ] Heart Attacks
- [ ] Bleeding Disorder
- [ ] Varicose veins
- [ ] Pacemaker or similar device
- [ ] Other Heart / Blood Disease not discussed

Gastrointestinal Symptoms – *Required*

- [ ] None
- [ ] Diabetes
- [ ] Jaundice
- [ ] Irregular or absent bowel movement
- [ ] Ulcer
- [ ] Indigestion

Genitourinary Symptoms – *Required*

- [ ] None
- [ ] Trouble Urinating
- [ ] Kidney Infection
- [ ] Prostate Trouble

Genitourinary Symptoms (Female only)

- [ ] None
- [ ] Hot Flashes
- [ ] Irregular / Absent Cycle
- [ ] Cramping / Backache

*** Have you ever been admitted to the HOSPITAL for any reason ? (If Yes, please provide details and dates)**

- [ ] Yes

- [ ] No

Please list any and all SURGERY'S including details and dates

1.
2.

Please list your current Medications, Herbs, Supplements.

Have you ever had any FRACTURES (broken bones)? (If Yes, please provide details and dates) – *Required*

☐ YES

☐ NO

Have you ever been diagnosed with Cancer ? (If Yes, please provide details and dates) – *Required*

☐ YES

☐ NO

Women: Are you currently PREGNANT ? (if so how many weeks into your pregnancy are you, and your estimated due date)

☐ YES

☐ NO

Women: Currently on Birth Control?

Select an option...

Number of Children

Select an option...

Do you SMOKE cigarette's or vape/e-cig? – *Required*

☐ YES (how often and amount (1/2 pack, one full pack,etc)

☐ No

Please list any and all Allergies.

FAMILY Medical History (Please check all applicable conditions) and LIST the AGE & RELATION of family member if deceased). – *Required*

☐ Stroke

☐ Cancer

☐ Headaches or Migraines

☐ High or Low blood pressure

☐ Diabetes

☐ Heart Disease

- [ ] Fainting or Dizziness

- [ ] Circulatory Problems

- [ ] Neurological disorders

- [ ] Kidney disease

- [ ] Crohn's Disease/Ulcerative Colitis

- [ ] Pelvic Inflammatory disease

- [ ] Asthma/Respiratory disorders

- [ ] Rheumatoid arthritis

- [ ] Osteoarthritis/Degnerative disc/bone disease

- [ ] Osteoporosis

- [ ] Fibromyalgia

- [ ] Epilepsy-Seizures

- [ ] Skin Conditions

☐ Multiple Sclerosis

☐ None

What are your main interests, recreational activities, and hobbies?

Physical activity level/Exercise

☐ No exercise ☐ Yes (1-2x/week) ☐ Yes (3-5x's/week) ☐ Yes (daily)

Please add any additional information that you feel is relevant to your health history.

Insurance Information

Please provide your Social Security Number – *Required*

#:

Will we be working with Insurance? Please provide information regarding your Primary and/or Secondary Insurance. – *Required*

☐ No

☐ Yes

☐ Primary Carrier:

☐ I.D.#:

☐ Secondary:

☐ I.D.#

If YES to Insurance, where would you like statements sent?

☐ Self

☐ Other (provide Name, Address, Phone, and Email)

Section 3

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like email notifications of new, cancelled, and rescheduled appointments

News and Special Promotions

☐ Yes, I would like to receive news and special promotions by email

New Patient Health Intake Form & FRI — Consents

Accuracy of Information

☐ I certify that the above medical information is correct and in full to my specific health history to my knowledge.
– Required

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that

my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree – *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctors day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, release our staff the permission to deny any future treatment or appointment. Tillman Family Chiropractic, PLLC reserves he right to dismiss any member of our office if No Show appointments exceed 3 visits within one calendar year.

☐ I am aware of the Cancellation Policy. – *Required*

Consent to Treatment

I hereby request and consent to the performance of chiropractic exam, adjustments, and/or adjunctive therapies on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me which by working for or associated with or serving as back-up for the doctor named above. I understand that results are not guaranteed and are informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains/strains that may occur in extremely rare cases. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time, based upon the fact then known, are in my best interest. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

☐ I am aware of the risks & consent fully – *Required*

Financial Obligation

The undersigned agrees that if this account is not paid when due, and Tillman Family Chiropractic, PLLC should retain an attorney or collections agency for collection, the undersigned agrees to pay all costs of collection including court costs, reasonable interest, reasonable attorneys fees, reasonable collection agency fees, and fees on any returned checks.

☐ I agree – *Required*

Signature

Draw Type

x ______________________________

Continue