BASARICH CHIROPRACTIC, INC.

Upper Cervical Chiropractic, Your Lifeline to a Quality Life

Name_____ Date_____
Address _____ City/Zip_____
Cell_____ Work_____ Home Phone _____
The Best Number To Contact: (Cell Work Home) Don't Call after _____ pm
E-mail Address _____ S.S.#_____-____-_____
Occupation_____ Employer_____ Birth Date _____
Marital Status: Single/Married/Divorced/Widowed Spouse/Partner's Name_____
Children – Names/Ages_____
Who Referred You To Our Office?_____
Past Chiro Care? Y / N Dr's Name _____ Last Visit _____
Current Medical Care? Y / N Reason _____
Current Drugs/Meds _____
Reason for consulting our office_____
Is your reason related to Job/Sports/Auto/Fall/Chronic Discomfort/Home Injury/Other _____
If job related, have you reported your accident to your employer? Y/N Report Date_____
When did condition begin?_____ Has the condition Gotten Worse/Stayed Constant/Comes & Goes
Does this condition interfere with Work/Sleep/Daily Routine/Other Activities _____
Has this condition occurred in the past? Y/N Explain_____
Have you seen a doctor for this condition? Y/N Dr's Name_____
Type of Treatment_____ Results_____
Health Habits: Smoke Y/N _____packs/day Alcohol Y/N _____drinks/day Coffee_____cups/day
Water _____ounces/day Exercise Y/N Rarely/Moderate/Almost Daily Stress Level Low /Moderate/High
Diet/Nutrition *Unhealthy*/Mediocre/Healthy Do you wear Heel Lifts/Sole Lifts/Inner Soles/Arch Supports
Emergency Contact Name_____ Relationship _____
Emergency Contact numbers Work _____ Phone _____ Cell _____

PLEASE DESCRIBE YOUR CURRENT GOAL
FOR YOUR HEALTH & WELL-BEING.

- ☐ I am only concerned about relief of a particular symptom.
- ☐ I am only concerned about relief of a particular symptom, and preventing its return.
- ☐ I want to perform at my highest possible level.

Level of commitment: Low - 1 2 3 4 5 6 7 8 9 10 - HIGH

FINANCIAL POLICY

I understand that all services are to be paid in full at the time of service

Signature _____ Date _____

PERSONAL HISTORY

THE HUMAN BODY IS DESIGNED TO EXPRESS HEALTH AND FUNCTION NORMALLY. HOWEVER, EVENTS MAY OCCUR IN LIFE, WHICH CAN INTERFERE WITH THIS NATURAL ABILITY. THIS INTERFERENCE IS MOST COMMONLY CAUSED BY **VERTEBRAL SUBLUXATIONS**. THESE SUBLUXATIONS ARE SPINAL JOINTS NOT WORKING PROPERLY AND INTERFERING WITH TRANSMISSION OF MENTAL (NERVE) IMPULSES. SINCE NORMAL BODY FUNCTION IS GOVERNED BY THESE MENTAL IMPULSES, INTERFERENCE CAN BE CRITICAL TO YOUR HEALTH AND WELL BEING.

ANY STRESS TO WHICH YOUR BODY CANNOT ADAPT MAY CAUSE THESE SUBLUXATIONS. THESE STRESSES MAY BE PHYSICAL, CHEMICAL, OR EMOTIONAL IN NATURE. THE PRACTICE OF CHIROPRACTIC IS BASED ON THE LOCATION AND REDUCTION OF NERVE INTERFERENCE CAUSED BY THE ***VERTEBRAL SUBLUXATION***.

Please check any that you are experiencing or have experienced in the past. Although it may seem unrelated to the purpose of your visit, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

__ Headaches (Severe & Frequent)
__ Vision Problems
__ Eyes sensitive to Light
__ Sinus Problems
__ Loss of Smell
__ Loss of Taste
__ Dizziness
__ Vertigo
__ Ringing/Buzzing in Ears
__ Ear Infection
__ Frequent Neck Pain
__ Stiff Neck
__ Pain in Arms/Hands
__ Pain in Legs/Feet
__ Numbness in Arms
__ Numbness in Legs
__ Numbness in Fingers
__ Numbness in Toes
__ Pins & Needles in Arms
__ Pins & Needles in Legs
__ Poor Circulation in Hands
__ Poor Circulation in Feet
__ Sleeping Problems
__ Back Pain
__ Chest Pain
__ Difficulty Breathing
__ Shortness of Breath
__ Loss of Balance
__ Loss of Memory
__ Fatigue
__ Fainting
__Tension
__ Nervousness
__ Irritability
__ Depression
__ Cold Sweats
__ Fever
__ Heart Attack/Stroke
__ Congenital Heart Defect
__ Heart Surgery
__ Heart Surgery/Pacemaker
__ Heart Murmur
__ High/Low Blood Pressure
__ Tuberculosis
__ Asthma
__ Diarrhea
__ Constipation
__ Irritable Bowel Syndrome (IBS)
__ Arthritis
__ Diabetes
__ Thyroid Problems
__ Shingles
__ Hepatitis
__ Cirrhosis of the Liver
__ Kidney Problems
__ Epilepsy
__ Rheumatic Fever
__ Cancer
__ Anemia
__ Psychiatric Problems

Please tell us about any stress associated with your BIRTH (i.e. difficult delivery, drugs during labor, pre-natal ultrasound) Please be complete._____

_____

Please tell us about any stress associated with your childhood (i.e. falls, frequent illness/drugs). Please answer the questions - *What, When and How* and be complete._____

_____

Please tell us about any more recent stress or trauma (i.e. work stress, auto injuries, other trauma, illness/drugs). Please answer the questions - *What, When and How* and be complete._____

_____

Do you have ANY other health concerns, however unrelated they might be?_____

_____

For Women Only: Are you within 10 days of your last menstrual cycle? Y/N Are you pregnant? Y/N Are you nursing? Y/N Are you on birth control? Y/N Do you experience painful periods? Y/N Do you have irregular cycles? Y/N