AK HEALTH CONNECTION

Please print in ink. All pages must be completed before treatment.

DATE________________________

LAST NAME ____________________ FIRST_________________ MIDDLE INITIAL ___ SEX: M F MARTIAL STATUS: S M D W
ADDRESS ____ CITY ______________________ STATE _____ ZIP _____________
HOME PHONE ______________________ WORK PHONE ______________________ CELL PHONE _________________________
EMAIL ____
AGE ______ BIRTHDATE ____________ OCCUPATION _________________ EMPLOYER ________________________________
FOR FEMALES: Are you pregnant? ___________ If yes, how long? ___________ Date of last menstrual cycle? _________________

REFERRED BY: ____ PAST CHIROPRACTIC CARE: ☐ No ☐ Yes

CHIROPRACTOR'S NAME _____________________________________ Date of last visit __________________________________
Nature of problem you were treated for? ____
Did you experience any relief? ____
INSURANCE COMPANY 1. ____ 2. ____
Primary account holder's name:________________________________ Relationship to patient: ______________________________
His/Her Birthdate : __________________________ His/Her

LEGAL GUARDIAN INFORMATION BOX

NAME: ____ RELATIONSHIP TO MINOR PATIENT: ______________________

BIRTHDATE: ____________________ AGE: __________ SEX: M or F

I hereby authorize Dr. Greg Beauchamp to treat the above named minor and acknowledge that I am responsible for all costs of their treatments. I also swear by my signature that I am the custodial parent and/or legal guardian of the above named minor.

SIGNATURE: ____ DATE: _______________________________

ADDRESS: ____ CITY: _________________________ STATE: ______ ZIP: _________

What problems are you experiencing today? ____
____
Do you have any other problems? (Please list them in order of importance) ____
____
When did your problem first occur? ____
Have you had this problem before? _________ When? ____
Are your present problems due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto accident ☐ Personal Injury ☐ Other

Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Auto Carrier ☐ Other

Are you taking medications for this problem? (If yes, names.) ____
Please list all other medications, vitamins or minerals that you are presently taking: ____
____
Have you ever had any spinal taps or spinal injections? ☐ No ☐ Yes Were you ever knocked unconscious? ☐ No ☐ Yes
Have you ever had a prolonged lapse of memory? ☐ No ☐ Yes Explain: ____
Have you had spinal x-rays taken within the last year? ☐ No ☐ Yes When? ________________ By whom? ________________
For what ailments were these x-rays taken? ____
Do you suffer from any condition other than that for which you are now consulting us? _______________________________________
Have you had any unexpected or unexplained weight loss/gain within the past 5 years? Gained?______Lost?_______Weight?_______

PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE HAD OR PRESENTLY HAVE:

Allergies		Dental Problems		Kidney Stones		Sciatica	
Alcoholism		Diabetes		Leg Problems		Seizures	
Anemia		Diarrhea		Liver Disease / Cirrhosis		Severe Neck / Spine Injury	
Aneurysm		Digestion Problems		Loss of Memory		Shortness of Breath	
Arm Problems		Dizziness		Loss of Balance		Sinus Problems	
Arthritis		Epilepsy		Loss of Smell		Sleep Problems / Insomnia	
Asthma		Excessive Hunger		Loss of Taste		Sneezing w/ Temp.Change	
Autoimmune Disease		Excessive Thirst		Lower Back Problems		Skin Problems / Sensitivity	
Back Pain		Fatigue		Lung Disease		Sleep Disorders	
Bleeding Disorders		Frequent Urination		Macular Degeneration		Smoked	
Blood Pressure (High or Low)		Gallbladder Disease / Stones		Menstrual Problems		Spinal Curvatures	
Breast Lump or Pain		Glaucoma		Migraines		STD	
Broken Bones		Gout		Muscle Cramps		Stomach Problems	
Bronchitis		Headache		Neuritis		Stroke	
Bruise Easily		Hearing Loss		Neck Problems		Swelling of Ankles / Limbs	
Cancer		Heart Disease		Nosebleeds		Swollen Joints	
Cataracts		Heart Problems		Osteoporosis		Thyroid Condition	
Chest Pain		Hemorrhoids		Pacemaker		Tuberculosis	
Cold Extremities		High Blood Pressure		Parkinson’s Disease		Ulcers	
Constipation		Hives		Paralysis		Varicose Veins	
COPD / Emphysema		Hot Flashes		Poor Posture		Walking Problems	
Cramps (Abdominal / Muscle)		IBS		Poor Appetite		***OTHER:***	
CVA (stroke / TIA)		Irregular Heart Beat		Prostate Trouble			
Dementia / Alzheimer’s		Irregular Menstrual Cycle		Retinal Disease			
Depression		Kidney Infection		Ruptures			

Have you had any of these Cardiovascular Diseases?

Myocardial Infarction --- *Hypertension* --- *Hypercholesterolemia* --- *Bypass Surgery* --- *Coronary Artery Disease*

Do you have Diabetes? If so, what type? *TYPE I* --- *TYPE II* --- *JUVENILE*

Do you have any stomach / digestive issues? *Ulcers* --- *Reflux* --- *IBS*

What are your expectations from our office? *Pain Relief* --- *Lifestyle Change* --- *Other*

Please explain: ____

____

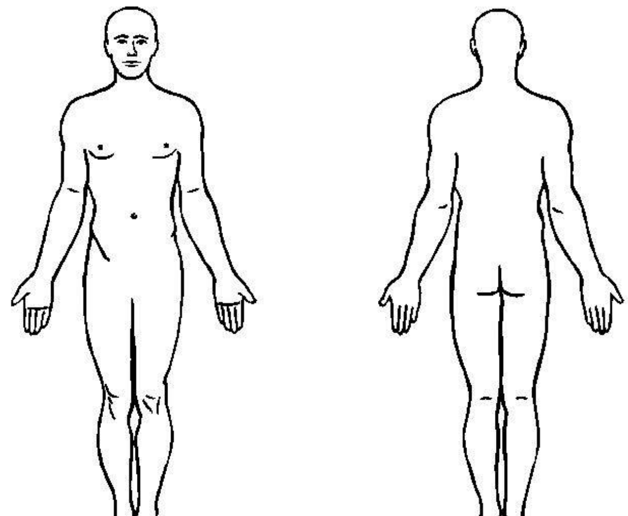
(USE BACK OF FORM IF MORE ROOM IN NECESSARY)

Which of the following factors affect your problem?

Please check only one for each factor.

	No Effect	Better	Worse
Movement			
Sitting			
Standing			
Walking			
Lying down			
During the night			
First thing in the morning			
Towards the end of the day			
During time of greatest activity			
While resting			
Before meals			
During meals			
After meals			
2-4 hours after meals			

Please mark your areas of pain on the figures shown below:



List your MAJOR diseases and approximate dates: ____

____

List your ALL surgeries and their approximate dates: ____

____

List any MAJOR dental work and its approximate date: ____

____

Please check the one box that most accurately describes you for each item listed.

	Daily	**Weekly**	**Occasionally**	**Never**
Alcohol				
Artificial Sweeteners				
Coffee				
Dairy – (ice cream, cheese, milk, yogurt, other…)				
Drugs				
Energy Products – (Monster, Red Bull, Rockstar, 5-Hour Energy, other…)				
Fresh & Homemade Foods				
Grains – (bread, pasta, cereal, other…)				
Popcorn / Nuts				
Preprocessed, Packaged, & Restaurant Food				
Smoking				
Soft Drinks				
Tea				
Water				

What oils do you use when you cook? ____________________ What oil do you use in salads? ____________________

If you add white sugar to any food, coffee or tea, how many teaspoons daily? ____________________

Do you use salt? *SPARINGLY* -- *MODERATELY* -- *FREELY*

Do you use vinegar? *SPARINGLY* -- *MODERATELY* -- *FREELY*

What foods disagree with you? ____

Do you have indigestion? Explain. ____

What did you eat yesterday?

BREAKFAST: ____

LUNCH: ____

DINNER: ____

SNACKS: ____

Is this your average diet for the past 3-4 years? ☐ No ☐ Yes If no, how long? ____________________

Please circle all foods you are fond of:

BREADS *BUTTER* *CEREAL* *FATS* *FRUITS* *MEATS* *SPICY* *SWEETS* *VEGETABLES*

PLEASE READ AND SIGN BELOW

Our policy is payment upon receipt of services. Patients are expected to pay for services at time of visit. We accept Cash, Check, Visa, MasterCard, American Express, and Discover. We require 24 hour notification for cancelling / rescheduling appointments. All missed appointments without a 24 hour notice will be charged $50.00.

I hereby authorize the Doctor to treat my condition, as he deems appropriate through the use of Chiropractic Health Care. The patient also agrees that he/she is responsible for all bills incurred at this office.

The Doctor(s) in AK Health Connection LLC, are not to be held responsible for any pre-existing medically diagnosed conditions.

PATIENT'S SIGNATURE: ____ Date: __________________

Guardian or Spouse's
Signature Authorizing Care: ____ Date: __________________