Background And Personal Information

Name (last)_____ (first)_____ (mi)_____ Pronouns _____

How would you like to be addressed?_____ Birthdate_____/_____/_____ Age _____

Home Address (street)_____

(city)_____ (state)_____(zip)_____

Phone Number (_____)_____ Email Address _____

Employer_____ Occupation_____

Male / Female (biological gender) Single / Married / Partnered / Divorced / Widowed / Separated

Partner's Name _____ Number of Children _____ Names and Ages _____

_____

Employer_____ Work Phone_____

Emergency Contact_____ Phone_____

Whom may we thank for referring you to Alternative Space Chiropractic?_____

If not through a personal or MD referral, how did you find us?_____

Reason for consulting ASC?_____

_____

_____

Previous Chiropractic: YES/NO If yes, date of last adjustment _____ Name of chiropractor_____

Reason for ending care:_____

Are you currently receiving medical attention and if so, for what?_____

_____

Please list any medications you are currently taking (prescription and non-prescription):_____

_____

_____

Please briefly describe your daily routine, including meals, snacks, supplements, and sleep _____

_____

What are your daily exercise habits?_____

_____

How would you rate your current health? Poor Fair Average Good Excellent

How would you describe your family's health? Poor Fair Average Good Excellent

Are you healthier now than you were 5 years ago? Y / N Why?_____

Do you know the health history of your birth? Y / N Home _____ Hospital _____ Natural _____ Intervention

Many things can contribute to imbalance in the body. Below are some of the most common causes. Please check any that apply or have applied to you in the past. State when if applicable.

Physical Stress	Emotional Stress	Chemical Stress
____ Birth Trauma	____ Relationships	____ Environmental
____ Slip/Fall	____ Career	____ Smoker
____ Car Accidents	____ Family	____ 2nd hand smoke
____ Sports Injuries	____ Financial	____ Caffeine
____ Physical Abuse	____ Pace of Life	____ Alcohol
____ Heavy Physical Labor	____ Quick temper	____ "Diet/sugar-free" food
____ Poor Posture	____ Holding in feelings	____ Soda intake
____ Heavy computer use	____ Perfectionism	____ Prescription drugs
____ Repetitive movements	____ Procrastination	____ Junk food
____ Prolonged driving/standing	____ Depression	____ Recreational drugs

What do you feel is the primary stress in your life?_____

Why is your health important to you (how will your life be better and what will you do once you reach your health goals)?

_____

_____

Financial Information: Who is responsible for this account with Alternative Space Chiropractic?_____

Is there anything else you would like us to know?_____

Joshua Pickell DC does not offer to diagnose or treat any symptom or condition. Our purpose is to help your body express its innate ability to heal by removing interfering patterns called subluxations. If a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider.

I, _____ , have answered the above questions to the best of my knowledge. Based on the information provided, I grant Joshua Pickell, DC permission to assess, locate, and release my subluxation patterns.

Your signature _____ **Date**_____

Notice of Privacy Practices
Acknowledgment Form

We will never share your personal or private information with others.

We may only disclose information about you in the following ways:

- To another health-care provider, hospital or facility if they request it in order to assist them in caring for you.
- To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.
- If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you correspondence by email.

My signature acknowledges I have read this notice, understand it and agree with the policies explained.

Name (Print)_____

Signed _____ Date _____/_____/_____