WELCOME to Gowrie Family Chiropractic and THANK YOU for your interest as a patient in our clinic. Our methods have enabled our patients to achieve their goals. Once we have determined we can help you, we will come up with a plan so your health is a top priority. Thank you again for your interest in becoming a patient in our clinic.

Patient Name

Date

Patient Information

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip:_____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____

Marital Status: S M D W

Spouse Name:_____ Work Phone ( ) _____

Cell Phone ( ) _____ Spouse's Employer: _____

Is your spouse a patient in the clinic? ____ Yes ____ No

What is your work status? ___Employed ____Full Time Student ____Part Time Student ____Other

Occupation: _____ Employer Name: _____

School:_____

Is it okay to call you at work? ____Yes ____No

Emergency Contact:

Contact name:_____

Contact number:_____

How did you hear about our clinic? Or who referred you?

___Family Member ___Friend ___Physician ___Employer __Yellow Pages

___Newspaper Ad ___Sign on Building ___Website ___Other

If you selected "family member", "friend", or "physician" please enter their name below:

_____

If you selected "Other" please describe:

_____

Purpose For The Visit

Reason for this visit:_____

Is this related to an accident or specific injury? ___Yes ___No If yes, when: _____/_____/_____

Describe:_____

When did these symptoms start? Month _____ Day _____ Year_____

How often do you experience your symptoms? ___Constantly ___Frequently ___Occasionally

What describes the nature of your symptoms?

___Sharp ___Dull ache ___Numb ___Shooting

___Burning ___Tingling ___Stabbing

How are your symptoms changing?
___Getting better ___Not changing ___Getting Worse

During the past 4 weeks, indicate the average intensity of your symptoms (0=none 10=unbearable)
___0 ___1 ___2 ___3 ___4 ___5
___6 ___7 ___8 ___9 ___10

During the past 4 weeks, how much has pain interfered with your normal work(including both work outside the home and housework)?
___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

During the past 4 weeks, how much of the time has your conditions interfere with your social activities?
___All the time ___Most of the time ___Some of the time ___None of the time

Is there anything the relieves your symptoms? __Yes ___No If yes, explain:_____

Have you been treated for this before? ___Yes ___No When were you last Treated? ____/____/____

Experience with Chiropractic

Have you seen a Chiropractor before? Yes No Who? _____

Reason for visit(s):_____

What test have you had for your symptoms? __X-Ray ___MRI ___Ct Scan ___Other

What treatment did you receive for your symptoms? ___Adjustment ___PT ___Medication

__Surgery ___Other How did you respond?_____

Health & Lifestyle

Medical Conditions:
__Arthritis __Cancer __Diabetes __Heart Disease __Hypertension __Stroke
__Psychiatric illness __Skin Disorder

Surgeries?_____

Allergies: __Eggs __Fish __Milk or Lactose __Peanut __Soy __Sulfites __Wheat/Gluten

Family History:

__Arthritis (parent)	__Arthritis (sibling)
__Cholesterol (parent)	__Cholesterol (sibling)
__Cancer (parent)	__Cancer (sibling)
__Diabetes (parent)	__Diabetes (sibling)
__Heart problems (parent)	__Heart problems (sibling)
__High Blood Pressure (parent)	__High Blood Pressure (sibling)
__Stroke (parent)	__Stroke (sibling)
__Thyroid (parent)	__Thyroid (sibling)

Social History:
__Caffeine used occasionally __Caffeine used often __Chewed tobacco occasionally
__Chew Tobacco Often __Drink alcohol occasionally __Drink alcohol often
__Exercise not at all __Exercise occasionally __Exercise often
__Experience stress occasionally __Experience stress often __Smoke 1 pack or less a day
__Smoke more than 1 pack a day

Do you take any supplements (i.e. vitamins, minerals,
herbs)?_____

Pregnancy Release

This is to state that to the best knowledge that I am not pregnant and that Dr. Pudenz has my permission to perform an X-Ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle:____/_____/____

Patient Signature_____ Date _____/_____/_____

EHR Information:

Prefered Language_____ Ethnicity _____ Race_____

Smoking Status_____ Smoking start date _____ Tried to quit? ___Yes ___No

Type of Tobacco _____ Cigarettes _____ Chewing Tobacco _____ Cigar _____ Pipe _____Other

How much Tobacco do you use?_____ How long have you used Tobacco?_____

Current Medications and Dosage

Medication Alligeries

___ I choose to decline receipt of my clinical summary after every visit

I clarify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my use of signed statement of authorization with m y signature for required insurance submissions. I understand and agree that all services rendered to me will be charges to me, and I'm responsible for timely payment between an insurance carrier and myself.I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

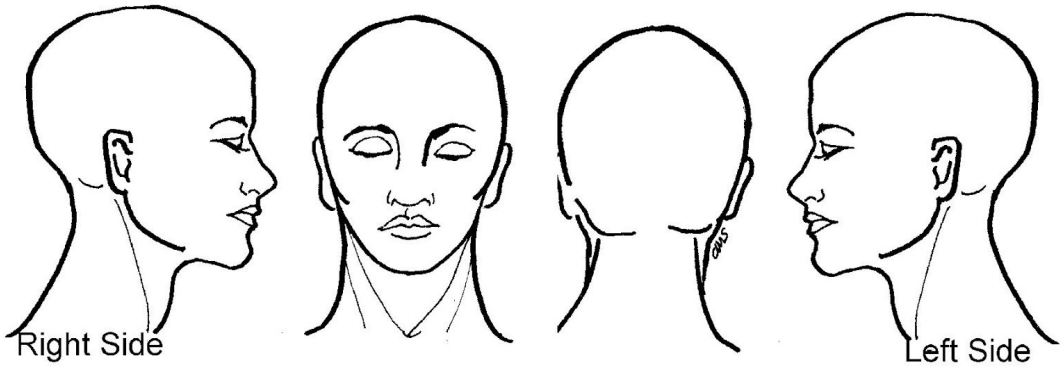
Signature:_____ Date:_____

Health Conditions.

The spine is the foundation of your health and the core strength of your body. Any kind of shift, discomfort movement to the spine will spread ultimately causing weakness and distortion to any area of the spine. They are reflected to you abnormal posture, which can lead to chronic pain, disease and possibly a shortened life span. Answer the following questions accurately so we may determine the full extent of your condition.

Cervical Spine (Neck)

Misalignment of the individual vertebrae or distortion of the complete cervical spine originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms recently or in the past.
Please indicate Y=Yes or N=No next to all conditions you've experiences



____Neck Pain ____ Pain in shoulders/arms/hands
_____ Headaches ____Dizziness
____ Numbness/tingling in arms/hands _____ Visual disturbances
____ Hearing disturbances ____ Weakness in grip ____Coldness in hands

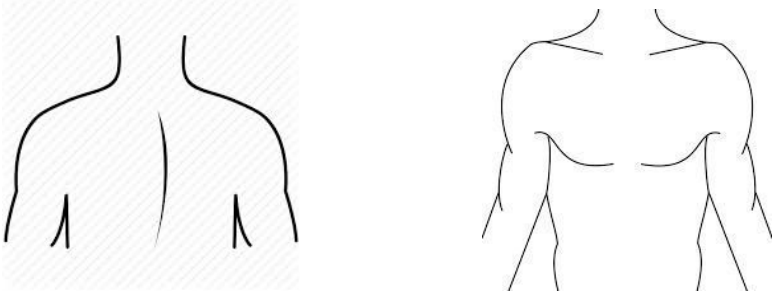
Please explain:

_____

_____

Thoracic Spine (upper back)

Misalignment of the vertebrae or distortion of the upper thoracic spine can result in many different health conditions. Answer the following questions accurately so we can determine the full extent of your conditions. **Please indicate Y=Yes or N=No next to all conditions you've experiences**



____ Heart Palpitations ____Lung infection/bronchitis
____Heart Murmur ____Asthma/Wheezing

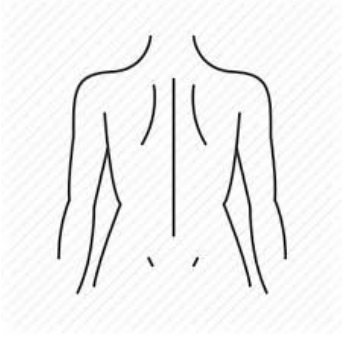
____Tachhycardia ____Shortness Of Breath
____Heart Attacks/Angina ____Pain on Deep Inspiration/Expiration
Please Explain:

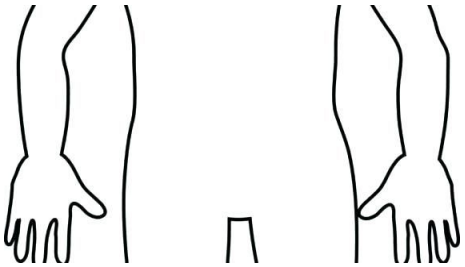
_____

_____

Thoracic Spine (Mid back)

Misalignment of the vertebrae or distortion to the thoracic spine may result in many health conditions
Answer the following question accurately so we can determine the full extent of your conditions.
Please indicate Y=Yes or N=No next to all conditions you've experiences





____Mid back Pain ____Nausa
____Diabetes ____ Pain in Ribs/Chest
____Ulcers/Gastritis ____Hypoglycemia/hyperglycemia
____indigestion/heartburn ____Reflux
____Tires/irritable after eating or when not having eaten for a while

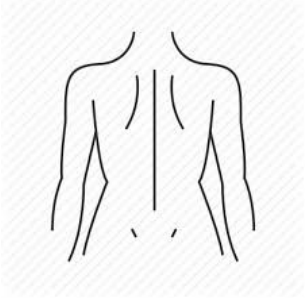
Please Explain:

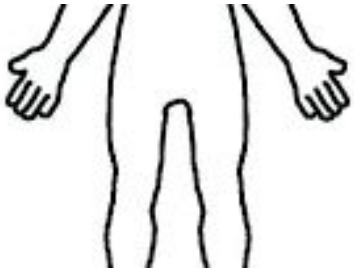
_____

_____

Lumbar Spine (Low Back)

Misalignment of the vertebrae or distortion of the lumbar spine can result in many health conditions.
Answer the following question accurately so we can determine the full extent of your conditions.
Please indicate Y=Yes or N=No next to all conditions you've experiences





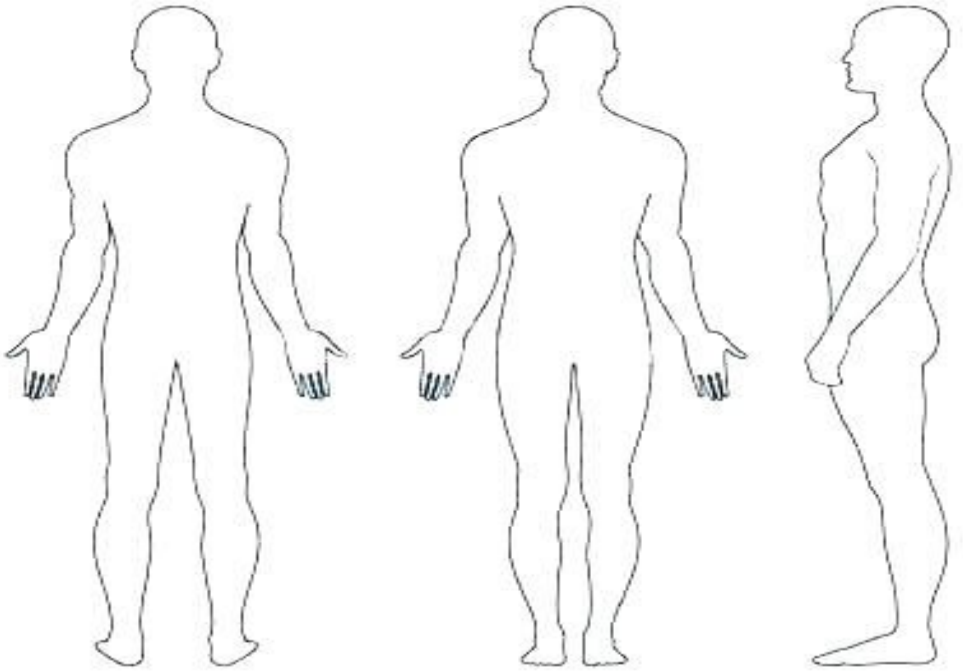
____Pain in hips/legs/feet ____Weakness/injuries in hips/knees/ankles
____Numbness/tingling in legs/feet ____Recurrent bladder infections
____Muscle cramps in legs/feet ____Low back pain

Please explain:

_____

_____

_____



Please use the following notations on the figures below to indicate the type and location of your symptoms, as it re;ates to the purpose of your visit today.

# = Numbness	X= Burning	/=Stabbing	0=Pins & Needles
+ = Dull Aches	S= Spams	F= Stiffness	T= Tingling

Gowrie Family Chiropractic & Acupuncture

1006 Market Street

Gowire, IA 50543

Phone 515-352-3880 Fax 515-352-3870

Chiropractic Care: I instruct the chiropractic to deliver the care in his or her professional judgement can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence are designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form and does not proclaim to cure any disease entity.

Privacy Verification: I may request a copy of the privacy policy and understand it describes how my personal health information is protected and releases on my behalf for seeking reimbursements from any involved third parties.

Permission to be contacted: I granted permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letter, or health information to me as an extension of my care in the office.

Payment Verification: I acknowledge that any insurance I may have is an agreement between the carrier and provider and that I am responsible for the payment of any covered or noncovered services I receive.

General Verification: To the best of my ability, the information I have supplied is completed and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Printed Name:_____

Signature:_____

Witness:_____