WELCOME TO ACN
ALLEN CHIROPRACTIC NEUROLOGY

Five Standards for New Patients

1.	All new patients are required to fill out a personal health questionnaire. Some items on the first page will have to be written down a second time.
2.	You will have a personal consultation with the doctor to discuss your intake form and heath problems.
3.	The doctor will perform diagnostic chiropractic, orthopedic, and neurological examination procedures.
4.	You will be advised if there is a need for additional procedures such as X-rays, MRI, or CT Scan.
5.	You will have a personal discussion with the doctor to discuss your care plan and treatment.

Confidential Patient Information

Name		Date
Address		City/State/Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone/Pager ( )
Email Address	Date of Birth	Current Age

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student

Employer	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Spouse's Name_____

Whom may we thank for referring you? _____

FEMALES ONLY – IN REFERENCE TO RADIOGRAPHIC IMAGING

I,_____, to the best of my knowledge confirm that I am not pregnant, and waive all responsibility to the Doctor.

Signature: Date:

MINORS ONLY – CONSENT FOR TREATMENT

I hereby authorize Dr. Julia Allen and whomever she may so designate as her assistant, to administer chiropractic care as she deems necessary to my son/daughter, _____, dated at Georgetown, TX this _____ day of _____, 20____.

Signature: Witnessed:

ALL PATIENTS – IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone ( )	Work Phone ( )	Cell Phone ( )

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	4.
2.	5.
3.	6.

Primary Ailment -_____

When did you first notice this condition:
Did it begin: □ Immediate or □ Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? □ No □ Yes. Where?
How often do you experience these symptoms? □ Constant (100% of day) □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
Is this condition progressively: □ Worsening □ Improving or □ Unchanged
What is the intensity of your symptoms? □ Severe □ Moderate □ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Is your pain □ Deep or □ Superficial
Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like Throbbing
Are you experiencing any of the following associated symptoms? □ Pins/Needles □ Tingling □ Numbness □ Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __Sitting for ___min., __Standing, __Walking, __ Lying, __Pushing, __Pulling, __Lifting ____ lbs., __Gripping Hot/Cold, __Coughing/sneezing, __Bowel Movements, __Mental Activities, __Bright lights, __Other_____, __Other_____, __Other_____
Please indicate what helps to alleviate the pain. □ Lying □ Sitting □ Walking □ Standing □ Rest □ Heat/Cold □ Medications _____ □ _____ □ _____ □ _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this ailment.

Additional Ailment - _____

When did you first notice this condition:
Did it begin: □ Immediate or □ Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? □ No □ Yes. Where?
How often do you experience these symptoms? □ Constant (100% of day) □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
Is this condition progressively: □ Worsening □ Improving or □ Unchanged
What is the intensity of your symptoms? □ Severe □ Moderate □ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Is your pain □ Deep or □ Superficial
Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like Throbbing
Are you experiencing any of the following associated symptoms? □ Pins/Needles □ Tingling □ Numbness □ Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __Sitting for ___min., __Standing, __Walking, __ Lying, __Pushing, __Pulling, __Lifting ____ lbs., __Gripping Hot/Cold, __Coughing/sneezing, __Bowel Movements, __Mental Activities, __Bright lights, __Other_____, __Other_____, __Other_____
Please indicate what helps to alleviate the pain. □ Lying □ Sitting □ Walking □ Standing □ Rest □ Heat/Cold □ Medications _____ □ _____ □ _____ □ _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this ailment.

IF YOU HAVE MORE THAN TWO AILMENTS, PLEASE ASK THE RECEPTIONIST FOR ADDITIONAL "AILMENT" FORMS.

Past Medical History

Please include any of your previous conditions.
If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas: ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations: ☐ No ☐ Yes Explain:
Surgeries: ☐ No ☐ Yes Explain:

Motor Vehicle Accidents: ☐ No ☐ Yes Explain:
Work Injuries: ☐ No ☐ Yes Explain:

Females Only - Menopausal Symptoms: ☐ None ☐ Yes Explain:

Habits

Cigarettes/Cigars	☐ None ☐ Yes How much per week?
Alcohol	☐ None ☐ Yes How many drinks per week? What type of Alcohol?
Coffee	☐ None ☐ Yes How many cups per week?
Exercise	☐ None ☐ Yes Hours/Days per week? Types?
Water	☐ None ☐ Yes Glasses per day?
Soft Drinks	☐ None ☐ Yes Amount per week? Types?
Sleep	☐ None ☐ Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? ☐ Yes ☐ No Explain:

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Neurological Disorders_____
☐ Autoimmune Disorders_____ ☐ Cancer_____
☐ Other _____

Personal Health History

Medications: Please list your current medications, how long you have been taking them and for what they are taken.
Vitamins and Minerals: Please list your current supplements.

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

GENERAL HEALTH HISTORY

P	C		P	C		P	C		P	C	
☐	☐	Mental Disorders	☐	☐	Diabetes	☐	☐	Pneumonia	☐	☐	Infective Disease
☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Fungal Infection
☐	☐	Tumors	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Alcoholism	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐	Arthritis
☐	☐	Drug Addiction	☐	☐	Rheumatic Fever	☐	☐	Parasites	☐	☐	Autoimmune Disease
☐	☐	Cancer	☐	☐	Scarlet Fever	☐	☐	Asthma	☐	☐	Chicken Pox

NERVOUS SYSTEM			EYES/EARS/NOSE/THROAT			GASTROINTESTINAL			MUSCULOSKELETAL		
P	C		P	C		P	C		P	C	
☐	☐	Depression	☐	☐	Vision Problems	☐	☐	Poor/Excess Appetite	☐	☐	Jaw Pain
☐	☐	Memory Loss	☐	☐	Flashing Lights	☐	☐	Excessive Thirst	☐	☐	Difficulty Chewing
☐	☐	Confusion	☐	☐	Black Spots	☐	☐	Frequent Nausea	☐	☐	Face Pain
☐	☐	Dizziness	☐	☐	Blurriness	☐	☐	Hemorrhoids	☐	☐	Neck Pain
☐	☐	Fainting	☐	☐	Hearing Loss	☐	☐	Black/Bloody Stools	☐	☐	Arm/Elbow Pain
☐	☐	Convulsions	☐	☐	Ringing in Ears	☐	☐	Digestive Problems	☐	☐	Wrist/Hand Pain
☐	☐	Weakness	☐	☐	Swallowing Difficulty	☐	☐	Abdominal Cramping	☐	☐	Mid Back Pain
☐	☐	Poor Balance				☐	☐	Gas/Bloating	☐	☐	Lower Back Pain
☐	☐	Twitches/Tremor				☐	☐	Heartburn	☐	☐	Thigh/Knee Pain
☐	☐	Cold/Tingle Extremities				☐	☐	Weight Problems	☐	☐	Ankle/Foot Pain
☐	☐	Sleeping Difficulties				☐	☐	Gall Bladder Problems	☐	☐	Difficulty Walking
☐	☐	Headaches				☐	☐	Liver Problems	☐	☐	Leg/Arm Fatigue

CARDIOVASCULAR			REPRODUCTIVE			GENITOURINARY		
P	C		P	C		P	C	
☐	☐	Chest Pain	☐	☐	Erectile Difficulties	☐	☐	Bladder Trouble
☐	☐	Irregular Heartbeat	☐	☐	Sexual Dysfunction	☐	☐	Painful Urination
☐	☐	High Blood Pressure	☐	☐	Menstrual Irregularity	☐	☐	Incontinence
☐	☐	Shortness of Breath	☐	☐	Menstrual Cramping	☐	☐	Discolored Urine
☐	☐	Lung/Congestion Problems	☐	☐	Venereal Infection			
☐	☐	Varicose Veins						
☐	☐	Ankle Swelling						

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any ☐ urgency, ☐ dribbling, or ☐ incontinence?	Do your stools ☐ Float or ☐ Sink?
Is this urination pattern consistent? ☐ Yes ☐ No	Are your bowel movements consistent? ☐Yes ☐No

CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number? ☐ Yes ☐ No

May we leave a message for you on your home answering machine? ☐ Yes ☐ No

May we leave a message for you with someone at your work phone number? ☐ Yes ☐ No

May we leave a voice mail message for you on your cell phone? ☐ Yes ☐ No

May we fax information that you request? ☐ Yes ☐ No

Financial Agreement and Medical Release of Records

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I hereby authorize Allen Chiropractic Neurology to furnish medical information concerning my present illness or injury to my family physician(s), referring physician(s) and insurance companies. I further authorize my family physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Allen Chiropractic Neurology.

I understand and agree to the above information.

Print name of patient: _____ Date: _____

Patient or Parent/Guardian signature: _____ Date:_____

Witness: _____ Date:_____