1st Choice Chiropactic, Charlette Fletcher, D.C.
1303 Delaware Avenue, Suite 12, Wilmington, Delaware 19806; Phone: 302-543-6072 Fax: 302-543-6082

`Patient Information
(Please Print Legibly. Use Black Ink Only)

Date____________ Name_____________________________________ SSN____
Address____City__________State_____Zip_________
Email _________________________Home#___________________Cell#__________________Fax#_____________
Age____ Gender M F Date of Birth_________Status: Married__ Single__ Widow__ Divorced__ Separated__ Other__
Employer/School______________________________Occupation___________________Office #_______________
Spouse__________________Occupation________________Employer__________________________________
Emergency Contact _________________________Phone ___________Relationship to Patient__________________
Family Medical Doctor____________________________ City________________ Office #____________________
Whom may we thank for referring you?________________________________ Phone #______________________

Policy Holder's Information

Relationship of patient to the insured: Self___ Child___ Husband ___ Wife ___ Other ___
InsuranceCompany____Address_________________________
Insured's Name __________________________________ Insured's Date of Birth ___________________________
Insured's S.S. # __________________________________ID/Policy #_____________________________________
Group #______________________________________ Insurance Phone # _________________________________
Is patient covered by additional insurance? Yes No If yes list ____

Authorization and Release

I certify that I, and /or my dependent(s) have insurance coverage with ________________________________ and assign directly to Dr. ______________ all insurance benefits, if any, otherwise payable to me for services rendered. I hereby IRREVOCABLY ASSIGN to 1st Choice Chiropractic any benefits under any policy of insurance, indemnity agreements, or any other collateral source for any service or charges provided by 1st Choice Chiropractic. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I hereby authorize 1St Choice Chiropractic to furnish my insurance company all information which said insurance company might request concerning my claim. 1st Choice Chiropractic may use my health care information and may disclose such information to the above name insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient, guardian or personal representative____
Printed Name______________________________ Relationship to Patient__________________ Date____________
Insurance Company: ____
Claim #: ____

Patient Condition

Reason for visit ____
Is this a recurrence, when was the first time you noticed this problem?______________________________
How did it originally occur? ____
Are the symptoms getting Better____ Worse_____ Not Changing? __________
How frequent is the condition? Constant _____ Daily _____ Intermittent ______ Night Only ______
How long does it last? All Day ______ Few Hours _________ Minutes _______ Other ________
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other ___________________
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____________________
Location of Complaint: ____
How frequent is complaint present. How long does it last? ____
Is there anything you can do to relieve the problem? Yes/No. If Yes Describe_______________________________
If no what have you tried that has not helped____
What makes the problem worse? Standing______ Sitting_______ Lying________ Bending________
Lifting____________ Twisting________ Other____
Does this complaint interfere with: work, home life, activities or sleep? Y/N __________________________________

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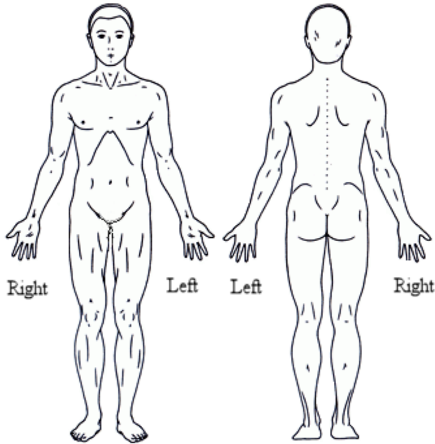
Using the symbols below, mark on the pictures where you feel pain



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^
Other______	^ ^ ^

Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where? ____________________________

Do you have any numbness or tingling in your body? Where?
____

Please Circle Degree of Pain 0=No Pain, 10 =Severe
0 1 2 3 4 5 6 7 8 9 10

Are you presently under a doctor's care for this complaint? Y/N
Doctors name:____

Previous interventions: treatments, medications, surgery, or care you've sought for your complaint
____
____

Previous injury or trauma:____

Medications: ____

Condition/s you are taking medications for: ____

Surgeries and dates____

Pregnancies, Date of Delivery & Outcomes
____

Date of the beginning of your last menstrual period?_____________ Any menstrual problems?________________

Family Health History:

Health problems of relatives: ____

Deaths in immediate family: ____

Cause of parents or siblings death & age at death ____

Social and Occupational History:

A. Level of Education: ____

B. Job description: ____

C. Recreational activities: ____

D. Do you take vitamins or supplements? Type and how often.___________________________________

E. Smoking and alcohol use. How often.____

Are there any other health concerns you would like to address? ________________________________

PREGNANCY

I fully understand that I am directly and fully responsible to said doctor of informing him if I am or become pregnant while being treated under his care. I acknowledge that I have read and understand the nature and purpose of revealing such information and its importance of how it effects my treatment. I agree that I will inform the said doctor if this condition exist or pregnancy does occur.

Patient Signature____Date________________________

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Past Health History:
Please mark each item below for each sign, symptom or condition you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy ______________

FOR WOMEN ONLY
__ Birth Control _________
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

CONDITIONS
__Anemia
__Cancer
__Diabetes
__Emphysema
__Glaucoma
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herniated Disc
__Multiple Sclerosis
__Osteoarthritis
__Osteoporosis
__Pacemaker
__Parkinson’ s Disease
__Pinched Nerve
__Rheumatoid Arthritis
__Seizures
__Stroke
__Thyroid Disorder
__Tumors, Growths
__Other______________
____
____

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I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.
Patient Signature____Date___________________________

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

________________________	________________________	___________
Printed Name	**Signature**	**Date**

WITNESS:

________________________	________________________	____________
Printed Name	**Signature**	**Date**

Date____________ Name______________________________________ DOB____