First Name:_____ MI:_____ **Last Name:**_____

Address:_____ City/State/Zip:_____

Phone Number:_____ **Email:**_____

Sex: ☐ **M** ☐ **F** Birthdate:_____ Occupation:_____

Emergency Contact:_____ **Phone Number:**_____

How did you hear about us?_____

REASON FOR VISIT

Reason for your visit:_____

Have you had a similar condition(s) in the past? ☐ **Yes OR** ☐ **No**

Is the pain: ☐ **Worse** ☐ **Better** ☐ **Same** ☐ **Comes and Goes**

How often do you have this pain?_____

Have you been treated by a medical physician for this condition? ☐ **Yes OR** ☐ **No**

ACTIVITIES OR MOVEMENTS THAT ARE DIFFICULT/PAINFUL TO PERFORM?

☐ **Sitting** ☐ **Walking** ☐ **Lying down** ☐ **Lifting**

What type of Pain?

☐**Sharp** ☐**Dull** ☐**Throbbing** ☐ **Aching** ☐**Burning** ☐**Tingling** ☐**Numbness**

☐ **Cramping** ☐**Stiffness** ☐**Swelling** ☐**Other:**_____

Are you over the age of 65? ☐ Yes OR ☐ No

POINDEXTER CHIROPRACTIC
WE'VE GOT YOUR BACK

Health History

Please list all medications (Including pain killers that you are taking:_____

_____

Please check any serious injuries you have had in the past 10 years:

☐ **FALLS** ☐ **HEAD INJURIES** ☐ **BROKEN BONES** ☐ **DISLOCATIONS** ☐ **SURGERIES**

☐ **OTHER:**_____

WOMEN: ARE YOU PREGNANT? ☐ **Yes OR** ☐ **No**

MEDICAL CONDITIONS (PLEASE CHECK ALL THAT APPLY):

☐ HEADACHE	☐ MUSCLE PAIN	☐ PAIN IN ARMS/HANDS
☐ LOSS OF MEMORY	☐ SENSITIVITY TO LIGHT	☐ DIFFICULTY SWALLOWING
☐ COLD HANDS	☐ COLD FEET	☐ HEAD SEEMS HEAVY
☐ TUBERCULOSIS	☐ CANCER	☐ DIABETES
☐ COLD SWEATS	☐ CONSTIPATION	☐ SHORTNESS OF BREATH
☐ IRRITABILITY	☐ NAUSEA	☐ NUMBNESS LEGS/FEET
☐ CHEST/RIB PAIN	☐ JAW PAIN	☐ NUMBNESS ARMS/LEGS
☐ DIZZINESS	☐ HEART DISEASE	☐ TINGLING IN ARMS/HANDS
☐ CLUMSINESS	☐ DIARRHEA	☐ TINGLING IN LEGS/FEET
☐ SLEEPING PROBLEMS	☐ STIFF NECK	☐ PROSTATE DISORDER
☐ BUZZING IN EARS	☐ FACE FLUSHED	☐ KIDNEY PROBLEMS
☐ TENSION	☐ NERVOUSNESS	☐ HIGH BLOOD PRESSURE
☐ LOSS OF SMELL	☐ FAINTING	☐ SEIZURE DISORDER
☐ STROKE	☐ ASTHMA	☐ LOSS OF STRENGTH-LEGS
☐ ULCER	☐ THYROID PROBLEM	☐ LOSS OF STRENGTH-ARM

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Poindexter Chiropractic to help determine appropriate and healthful chiropractic treatment. I am also aware that Poindexter Chiropractic does not take nor bill insurance or Medicare and I am responsible for all payments in full at the time of treatment.

Signature:_____ Date:_____

INFORMED CONSENT & RELEASE

I understand that chiropractic care, spinal decompression, and Cranial Facial Release offer benefits but also carry minimal risks, including rare cases of sprain/strain or disc irritation. Before treatment, a health history and exam will be performed to assess my condition, determine if care is appropriate, and decide whether referral or additional testing is needed. Findings and a care plan will be explained to me.

I **consent** to the necessary examinations and recommended chiropractic and/or decompression treatments. ☐ **Yes OR** ☐ **No**

TERMS OF ACCEPTANCE

Services Provided:
Poindexter Chiropractic offers affordable, routine chiropractic care to improve function, joint mobility, and overall wellness. We accept only patients who may benefit from this care.

Service Limitations:

- We **do not** bill insurance, Medicare, or any third party.
- We **do not** treat diseases or conditions outside joint dysfunction of the spine or extremities.
- We **do not** provide extensive diagnostics, X-rays, or invasive treatments.
- If X-rays, MRI or further testing are needed, referrals will be provided.

Financial Responsibility:

I understand I am fully responsible for payment at the time of service, and no insurance claims will be submitted on my behalf. ☐ **Yes OR** ☐ **No**

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received or read the HIPAA Notice of Privacy Practices.
☐ **Yes OR** ☐ **No**

I, _____, have read and understand these statements.
(Patient Printed Name)

Patient Signature: _____ **Date:** _____