SWEETGRASS
HEALTH & WELLNESS
Live Better, Live Longer!

Date:_____

Patient's Full Name:_____
(Last) (First) (Middle Initial)

Date of Birth:_____/_____/_____ Marital Status: S M W D

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Phone:_____ Email:_____

Employer:_____Occupation:_____Phone:_____

Spouse Name:_____ Spouse Date of Birth:_____/_____/_____

Complete below for patients under 18 and/or covered by the parents insurance:

Father's Full Name:_____ Date of Birth:_____/_____/_____

Address (if different from child)_____

City:_____State:_____Zip:_____ Contact Phone:_____

Mother's Full Name:_____ Date of Birth:_____/_____/_____

Address (if different from child)_____

City:_____State_____Zip:_____Contact Phone:_____

Please list any surgeries/procedures:

_____

_____

Please list any health conditions you may have (ex. Asthma, Thyroid problem, heart condition, etc.):

_____

_____

How did you hear about us:_____

(Females) Are you pregnant? Yes No

Do you have children? Yes No If so, how many?_____

Do you smoke? YES No

Do you drink alcohol? Yes No How Much_____

Do you exercise? YES No How often_____

Do you take any supplements? Yes No List_____

Have you seen a Chiropractor before? Yes No

Are you interested in a FREE analysis of your current supplementation? Yes No

Are you interested in learning more about WHOLE FOOD supplementation? Yes No

Reason For your visit:

What is your **PRIMARY** complaint:_____

_____

_____

_____

How did it begin?_____

When did it begin?_____

CIRCLE CHARACTER: Dull Ache Sharp Stabbing Burning Throbbing Stiffness

DURATION: Intermittent Occasional Frequent Constant

PAIN: 1 2 3 4 5 6 7 8 9 10

AGGREVATING FACTORS: Cough/Sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Sleeping Bright Lights Noise Other:_____

RELIEVING FACTORS: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

What is your **SECONDARY** complaint:_____

_____

_____

_____

How did it begin?_____

When did it begin?_____

CIRCLE CHARACTER: Dull Ache Sharp Stabbing Burning Throbbing Stiffness

DURATION: Intermittent Occasional Frequent Constant

PAIN: 1 2 3 4 5 6 7 8 9 10

AGGREVATING FACTORS: Cough/Sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Sleeping Bright Lights Noise Other:_____

RELIEVING FACTORS: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

Do you have a **THIRD** complaint:_____

_____

_____

_____

How did it begin?_____

When did it begin?_____

CIRCLE CHARACTER: Dull Ache Sharp Stabbing Burning Throbbing Stiffness

DURATION: Intermittent Occasional Frequent Constant

PAIN: 1 2 3 4 5 6 7 8 9 10

AGGREVATING FACTORS: Cough/Sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Sleeping Bright Lights Noise Other:_____

RELIEVING FACTORS: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

Please list anyone in your family, other than yourself, that we may disclose personal health information, appointment reminders, information about treatment or other health related services to:

_____	_____	_____/_____/_____
Name of authorized person	Relationship	Date
_____	_____	_____/_____/_____
Name of authorized person	Relationship	Date
_____	_____	_____/_____/_____
Name of authorized person	Relationship	Date

The Health Professionals and staff of Sweetgrass Chiropractic are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. When the Health Professionals and staff use or disclose your "PHI" the Healthcare Professionals and staff are required to abide by the terms of this notice. Your "PHI" may be used and disclosed to provide treatment and other services to you-for example, to diagnose and treat your injury or illness. In addition, you may be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Your "PHI" may be disclosed to other providers involved in your treatment.

Signature_____ Date_____/_____/_____