Future One Chiropractic

(470) 409-4803
8326A Office Park Dr.
Douglasville, GA 30134

Name:______________________________ Date:________________

Email:____

Phone Number:____________________ Age:_____ Gender: M F DOB:____________

Address:______________________________ Apt number:__________

City:____________________ State:_________ Zip:____________

Emergency Contact:_________________________ Phone:____________________

Employeer: ____

Occupation:____

Referred by:____

Major complaint:____

When did it start:____________________ Have you seen another chiropractor for this? YES NO

Recent surgeries (last 5 yrs):____

Recent traumas/accidents (last 5 yrs):____

Current conditions:____

Medications:____

Supplements:____

Family conditions (mother, father, grandparents):______________________________

Alcohol: __________/day, week, month Smoking:_____pack/day Water:____________oz/day

History of Other Conditions

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] High Cholesterol
[ ] Neck Pain
[ ] Midback Pain
[ ] Lowback Pain
[ ] Headaches
[ ] Canal Stenosis *Level:*______
[ ] Disc Herniation *Level:*______
[ ] Shoulder pain
[ ] Elbow Pain
[ ] Wrist/Hand Pain
[ ] Chest Pain
[ ] Hip Pain
[ ] Knee Pain
[ ] Ankle Pain
[ ] Foot Pain
[ ] Scoliosis

[ ] Fractures
Location:_______________
[ ] Torticollis
[ ] Anxiety
[ ] Depression
[ ] Stressed
[ ] Endometriosis
[ ] Infertility
[ ] Prostate Condition
[ ] Erectile Dysfunction
[ ] Tuberculosis
[ ] Asthma
[ ] Pneumonia
[ ] Hepatitis A, B, C, D
[ ] Meningitis
[ ] Cancer ____________
[ ] Hair Loss
[ ] Thyroid Conditions

[ ] Digestive Conditions
[ ] Nutritional Deficiency
[ ] Celiac Disease
[ ] Ulcerative Colitis
[ ] Psoriatic Arthritis
[ ] Rheumatoid Arthritis
[ ] Enteropathic Arthritis
[ ] Weight Loss
[ ] Eating Disorders
[ ] Other Ear, Nose, Throat
[ ] Other Digestive Disorders
[ ] Other Skin Disorders
[ ] Other Lung Disorders
[ ] Other Heart Conditions
[ ] Other Musculoskeletal
[ ] Reproductive Disorders
[ ] Urinary Conditions
[ ] Other:_______________

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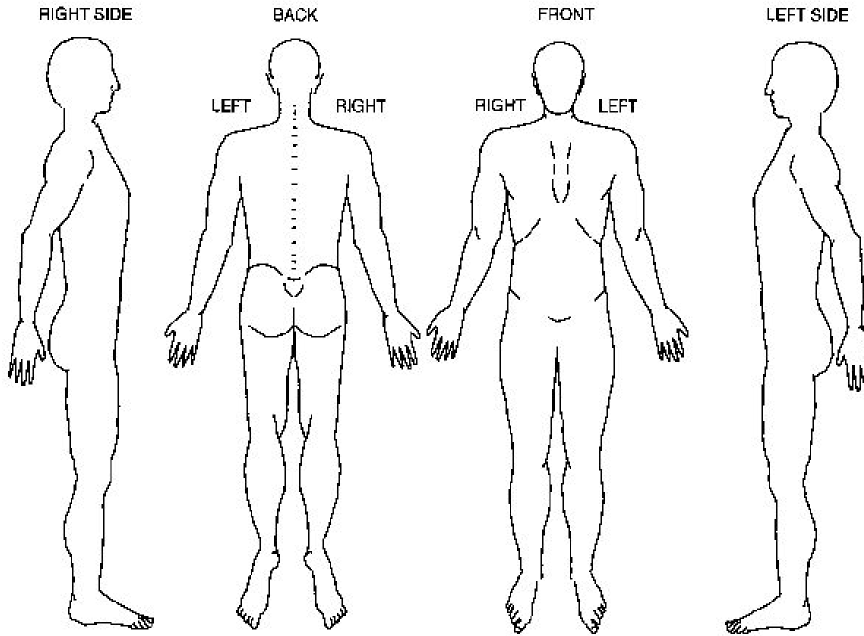

Pain: X

Stiff: S

Burn: B

Numb: N

Tingling: T

Temp: Hot (H) Cold (C)

Please mark your symptoms on the image above:

Females ONLY:
First day of last menstrual cycle:__________________ Are you pregnant: ___Yes ___No ___ I don't know
Menopause: ___Yes Means of menopause: ___Natural ___ Surgically Induced ___Other___________
Previous deliveries: Vaginal Cesarean VBAC Epidural None

Informed Consent to Treatment:
The risks to chiropractic care are minimal and the lowest among current healthcare practices. However, certain complications may occur including but not limited to increased pain at adjusted regions, headaches, slight dizziness, muscle soreness, fracture, disc herniation, and stroke. Many of these complications indicate changes in the nervous system and are considered normal for the course of treatment. However, more serious complications have been studied to occur in those with severe predisposing conditions, or there is a lack of evidence correlating chiropractic specifically.
______ (Initial) I Understand

I have completed this history to the best of my knowledge and therefore it reflects an accurate document of my current health conditions as my signature confirms. I understand the conditions of chiropractic care and consent to further treatment with this provider.

______________________________ ______________________________ ___________
Name Signature Name Print Date: