CRYSTALIGN CHIROPRACTIC
Asheville's Transformative Healing Center

New Patient Information

Date ______________

Legal Name ____

Preferred Name _________________________ Date of Birth ____/____/____ Age _______

Gender: please circle M/F

Address ____

Email ____ Phone (______) _______________

Can we send you our email newsletter for important practice updates and information about upcoming events or classes? Yes / No

If the patient is a minor, Parent/Guardian's Name ____________________________________

Please mark the services you are interested in:

___ Chiropractic Care
___ Sound Healing for stress relief
___ Hypnotherapy
___ Cold Laser

How did you hear about Crystalign Chiropractic?

____

How will you pay today? Cash Check Credit Card

We prefer cash :) Payment is due at time of service.

Health Information

What are your goals for your health? ____

____

Present Health Concerns

Please list your top 3 most important health concerns today in order of priority:

Concern	Onset (When did it start?)	Frequency (How often?)	Severity (1-mild - 10-severe)
1.			
2.			
3.			

Have you seen any other practitioners for these concerns? Yes No

What was the outcome? ____

Do your health concerns prevent you from accomplishing self-care? Mark all that apply.

___ Personal hygiene (showering, oral care)

___ Using the bathroom

___ Ambulating (walking, changing position)

___ Sleeping

___ Eating (preparing food, regular meals)

___ Dressing

What else do you want to do that your health concern(s) prevent or limit you in accomplishing?

____

____

Health History

Do you have a primary care doctor? Yes No Name: ________________________________
Have you previously seen a chiropractor? Yes No Date of last visit: ___________________
Who else is on your healthcare team? (PT, massage therapist, acupuncturist, etc)
____

Have you had any accidents or injuries? (type and approx date) __________________________
____
____

Please list the reason and approximate date of any:

- ER visits: ____
- Hospitalizations: ____
- Surgeries: ____

Please list any Medications and reason for such
medications:____
____

Please list any Supplements:
____
____

Lifestyle

What is your occupation? ____
Does your work affect your ability to keep good posture? __________________________________
How many hours per night of sleep do you get on average? ______________________________
How much do you drink daily of each of the following:

Water? _________________________ Herbal/Green tea? ________________________
Soda? __________________________ Coffee/Black tea? _________________________

Do you use tobacco? Yes (type, amount, frequency) ______________________________/ No
Do you use alcohol? Yes (amount, frequency) ___________________________________/ No
Does your health issue affect being able to enjoy your hobbies? Yes / No
What other health and wellness topics would you like to discuss during your visits with me?
(ex. nutrition, supplements, breathwork, exercises, stretches, yoga)
other:____

Family Medical History

Please list any important family medical history that could be relevant to your case:

____

____

Personal Medical History

Mark as follows:

C = currently experiencing I = experience intermittently R = resolved

D = officially diagnosed condition ? = uncertain or have questions regarding

Musculoskeletal

Pain in or injury to: ___ Neck ___ Mid-back ___ Low back ___ Pelvis ___ Shoulder ___ TMJ

___ Elbow ___ Wrist ___ Hand ___ Hip ___ Knee ___ Ankle ___ Foot

___ Broken bones ___ Osteoporosis / Osteopenia ___ Joint pain / swelling

___ Muscle pain ___ Muscle weakness ___ Joint stiffness

___ Arthritis ___ Scoliosis ___ Spasms/cramps

___ Other musculoskeletal condition ____

Neurological/Psychological

___ Headaches ___ Dizziness/lightheadedness ___ Vertigo

___ Fainting ___ Loss of balance ___ Change in gait

___ Seizure / Epilepsy ___ Insomnia (falling/staying asleep) ___ Tics

___ Nerve pain ___ Abnormal sensation / numbness ___ Paralysis

___ Concussion / TBI ___ Poor concentration / Brain fog ___ Memory loss

___ Depression / Anxiety ___ Alcoholism / Substance abuse ___ History of abuse/trauma

___ Other neurological/psychological disorder ____________________________________

Endocrine/Immunological

___ Allergies ___ Thyroid disorder ___ Fatigue

___ Diabetes (Type 1, Type 2) ___ Heat / cold intolerance ___ Slow wound healing

___ Weight changes ___ Parasitic infection ___ Chronic infection

___ Cancer ___ Autoimmune condition(s)

___ Other endocrine/immunological disorder ____________________________________

Digestive

___ Nausea / Vomiting ___ Heartburn / reflux / GERD ___ Bloating / Gas
___ Difficulty swallowing ___ Constipation / Diarrhea ___ Abdominal pain/discomfort
___ Liver / gallbladder disease
___ Other digestive disorder ____

Cardiovascular

___ Heart disease ___ Heart attack / Angina ___ Arrhythmia / Palpitations
___ High cholesterol ___ High / Low blood pressure ___ Stroke / TIA
___ Blood clots / DVT ___ Bleeding disorder ___ Anemia
___ Other cardiovascular disorder ____

Respiratory

___ Bronchitis ___ Pneumonia ___ COPD / Emphysema
___ Asthma ___ Shortness of breath ___ Pleurisy
___ Other respiratory disorder ____
Number of cold/flu episodes in the past year _________

Eyes, Ears, Nose, and Throat

___ Visual disturbance ___ Change in/blurred vision ___ Glaucoma
___ Hearing loss ___ Ringing in ears/tinnitus ___ Loss of smell / taste
___ Sinus congestion ___ Hay fever/seasonal allergies ___ Hoarseness
___ Other EENT disorder ____

Skin and Hair

___ Eczema ___ Psoriasis ___ Rash ___ Hair thinning/loss
___ Other skin/hair ____

Genitourinary

___ Urinary tract infection ___ Urinary incontinence ___ Overactive bladder
___ Kidney infection ___ Kidney stone ___ Kidney disease
___ Other genitourinary disorder ____

Reproductive

___ Low sex drive ___ Sexually transmitted infection ___ Infertility
Where applicable: ___ Prostate condition ___ Erectile dysfunction
___ PMS symptoms ___ Heavy / light / absent menses ___ Painful menses
___ Endometriosis ___ Yeast infections ___ Breast pain / condition
___ Other reproductive disorder ____

CONSENT TO CHIROPRACTIC CARE

Congratulations for choosing the safest and most natural health care program ever conceived: Chiropractic. This painless, logical, and effective approach to health has been serving everyday people for over 120 years. It is licensed in every state, and in many countries as well. Chiropractic has the least chance of side effects of any other type of health care.

Methods of Care: Spinal adjustments done by hand, Arthrostim or activator tools, trigger point (muscular) therapy, extremity adjustments, heat, nutritional counseling, sound healing and energy balancing.

Risks: A minority of patients may notice muscle stiffness or soreness in the first few days after care. Complications are very rare but may include: rib or bone fracture, ligament or muscular strain/sprain, joint dislocation, or injury to intervertebral discs.

Risks of Remaining Untreated: Disc degeneration, loss of mobility, adhesions, scar tissue, loss of overall tone, decreased quality of life, and a continuation of chronic pain cycles.

- ❖ I fully understand these risks, and I fully consent to chiropractic care.
- ❖ I acknowledge that I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments) as well as the contents of this Consent.
- ❖ I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care with Crystalign Chiropractic.
- ❖ I understand that all patient information is kept confidential due to HIPPA.
- ❖ I understand that this office does not take any form of insurance.

____ ____________

Patient Signature (or Legal Guardian if patient is under 18 yoa) Date

Welcome to Crystalign Chiropractic, we are so happy you are here. Let's get started! :)