

**AK HEALTH CONNECTION**

Please print in ink. All pages must be completed before treatment.

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_ SEX: M F MARTIAL STATUS: S M D W

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMAIL \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

FOR FEMALES: Are you pregnant? \_\_\_\_\_ If yes, how long? \_\_\_\_\_ Date of last menstrual cycle? \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PAST CHIROPRACTIC CARE:  No  Yes

CHIROPRACTOR'S NAME \_\_\_\_\_ Date of last visit \_\_\_\_\_

Nature of problem you were treated for? \_\_\_\_\_

Did you experience any relief? \_\_\_\_\_

INSURANCE COMPANY 1. \_\_\_\_\_ 2. \_\_\_\_\_

Primary account holder's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

His/Her Birthdate : \_\_\_\_\_ His/Her Social Security # \_\_\_\_\_

**MINOR INFORMATION BOX**

NAME: \_\_\_\_\_ RELATIONSHIP TO MINOR PATIENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ SEX: M or F

I hereby authorize Dr. Greg Beauchamp to treat the above named minor and acknowledge that I am responsible for all costs of their treatments. I also swear by my signature that I am the custodial parent and/or legal guardian of the above named minor.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

What problems are you experiencing today? \_\_\_\_\_

Do you have any other problems? (Please list them in order of importance) \_\_\_\_\_

When did your problem first occur? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_ When? \_\_\_\_\_

Are your present problems due to an injury?  No  Yes  On the job  Auto accident  Personal Injury  Other

Has the accident been reported?  No  Yes  To Employer  Auto Carrier  Other

Are you taking medications for this problem? (If yes, names.) \_\_\_\_\_

Please list all other medications, vitamins or minerals that you are presently taking: \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  No  Yes Were you ever knocked unconscious?  No  Yes

Have you ever had a prolonged lapse of memory?  No  Yes Explain: \_\_\_\_\_

Have you had spinal x-rays taken within the last year?  No  Yes When? \_\_\_\_\_ By whom? \_\_\_\_\_

For what ailments were these x-rays taken? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

Have you had any unexpected or unexplained weight loss/gain within the past 5 years? Gained? \_\_\_\_\_ Lost? \_\_\_\_\_ Weight? \_\_\_\_\_

**PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE HAD OR PRESENTLY HAVE:**

Allergies	Dental Problems	Kidney Stones	Sciatica
Alcoholism	Diabetes	Leg Problems	Seizures
Anemia	Diarrhea	Liver Disease / Cirrhosis	Severe Neck / Spine Injury
Aneurysm	Digestion Problems	Loss of Memory	Shortness of Breath
Arm Problems	Dizziness	Loss of Balance	Sinus Problems
Arthritis	Epilepsy	Loss of Smell	Sleep Problems / Insomnia
Asthma	Excessive Hunger	Loss of Taste	Sneezing w/ Temp.Change
Autoimmune Disease	Excessive Thirst	Lower Back Problems	Skin Problems / Sensitivity
Back Pain	Fatigue	Lung Disease	Sleep Disorders
Bleeding Disorders	Frequent Urination	Macular Degeneration	Smoked
Blood Pressure (High or Low)	Gallbladder Disease / Stones	Menstrual Problems	Spinal Curvatures
Breast Lump or Pain	Glaucoma	Migraines	STD
Broken Bones	Gout	Muscle Cramps	Stomach Problems
Bronchitis	Headache	Neuritis	Stroke
Bruise Easily	Hearing Loss	Neck Problems	Swelling of Ankles / Limbs
Cancer	Heart Disease	Nosebleeds	Swollen Joints
Cataracts	Heart Problems	Osteoporosis	Thyroid Condition
Chest Pain	Hemorrhoids	Pacemaker	Tuberculosis
Cold Extremities	High Blood Pressure	Parkinson's Disease	Ulcers
Constipation	Hives	Paralysis	Varicose Veins
COPD / Emphysema	Hot Flashes	Poor Posture	Walking Problems
Cramps (Abdominal / Muscle)	IBS	Poor Appetite	<b>OTHER:</b>
CVA (stroke / TIA)	Irregular Heart Beat	Prostate Trouble	
Dementia / Alzheimer's	Irregular Menstrual Cycle	Retinal Disease	
Depression	Kidney Infection	Ruptures	

Have you had any of these Cardiovascular Diseases?

*Myocardial Infarction --- Hypertension --- Hypercholesterolemia --- Bypass Surgery --- Coronary Artery Disease*

Do you have Diabetes? If so, what type? *TYPE I --- TYPE II --- JUVENILE*

Do you have any stomach / digestive issues? *Ulcers --- Reflux --- IBS*

What are your expectations from our office? *Pain Relief --- Lifestyle Change --- Other*

Please explain: \_\_\_\_\_

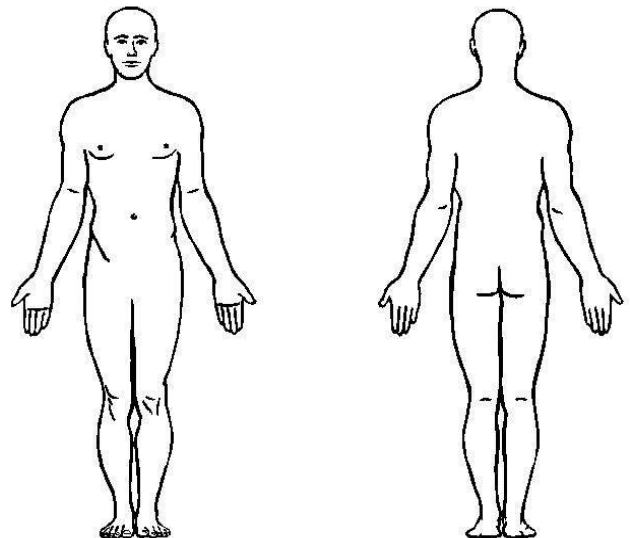
(USE BACK OF FORM IF MORE ROOM IN NECESSARY)

Which of the following factors affect your problem?

Please check only one for each factor.

	No Effect	Better	Worse
Movement			
Sitting			
Standing			
Walking			
Lying down			
During the night			
First thing in the morning			
Towards the end of the day			
During time of greatest activity			
While resting			
Before meals			
During meals			
After meals			
2-4 hours after meals			

Please mark your areas of pain on the figures shown below:



List your MAJOR diseases and approximate dates: \_\_\_\_\_

List your MAJOR surgeries and their approximate dates: \_\_\_\_\_

List any MAJOR dental work and its approximate date: \_\_\_\_\_

Please check the one box that most accurately describes you for each item listed.

	Daily	Weekly	Occasionally	Never
Alcohol				
Artificial Sweeteners				
Coffee				
Dairy – (ice cream, cheese, milk, yogurt, other...)				
Drugs				
Energy Products – (Monster, Red Bull, Rockstar, 5-Hour Energy, other...)				
Fresh & Homemade Foods				
Grains – (bread, pasta, cereal, other...)				
Popcorn / Nuts				
Preprocessed, Packaged, & Restaurant Food				
Smoking				
Soft Drinks				
Tea				
Water				

What oils do you use when you cook? \_\_\_\_\_ What oil do you use in salads? \_\_\_\_\_

If you add white sugar to any food, coffee or tea, how many teaspoons daily? \_\_\_\_\_

Do you use salt? *SPARINGLY -- MODERATELY -- FREELY*

Do you use vinegar? *SPARINGLY -- MODERATELY -- FREELY*

What foods disagree with you? \_\_\_\_\_

Do you have indigestion? Explain. \_\_\_\_\_

What did you eat yesterday?

BREAKFAST: \_\_\_\_\_

LUNCH: \_\_\_\_\_

DINNER: \_\_\_\_\_

SNACKS: \_\_\_\_\_

Is this your average diet for the past 3-4 years?  No  Yes If no, how long? \_\_\_\_\_

Please circle all foods you are fond of:

*BREADS BUTTER CEREAL FATS FRUITS MEATS SPICY SWEETS VEGETABLES*

**PLEASE READ AND SIGN BELOW**

Our policy is payment upon receipt of services. Patients are expected to pay for services at time of visit. We accept Cash, Check, Visa, MasterCard, American Express, and Discover. We require 24 hour notification for cancelling / rescheduling appointments. All missed appointments without a 24 hour notice will be charged \$50.00.

I hereby authorize the Doctor to treat my condition, as he deems appropriate through the use of Chiropractic Health Care. The patient also agrees that he/she is responsible for all bills incurred at this office.

The Doctor(s) in AK Health Connection LLC, are not to be held responsible for any pre-existing medically diagnosed conditions.

PATIENT'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's  
Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_