Dr. Maria Maricich, D.C.

PATIENT INFORMATION

Date_____ ○Married ○Single ○Divorced ○Widowed

Name_____ What name do you prefer to be called?_____

Address_____ Whom may we thank for referring you? _____

City_____ State_____ Zip _____ Email _____

Home Phone _____SS#_____ May we add you to our email newsletter? Yes No

Birth Date___/____/____ Age ____ Sex ____Occupation_____Employer_____

Cell Phone _____ Do you have children_____ Ages_____

Who is responsible for your bill:
○Myself ○Health Insurance ○Workers' Comp. ○Auto Insurance ○Medicare

Previous chiropractic care: ○None ○Doctor's name & approximate date of last visit _____
Previous or other Wellness Doctor: ○None ○Doctor's name & date of last visit _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

When did the symptoms first appear? _____

Has this condition occurred before? ○Yes ○No

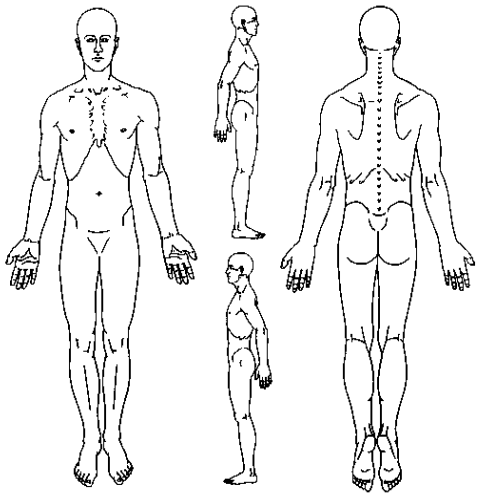
How often do you experience the symptoms?
○Constant 100% ○Frequent 75%
○Intermittent 50% ○Occasional 25% ○Rare 10%

What makes the symptoms worse? _____
What relieves the symptoms? _____

How would you describe the pain?
○Sharp ○Dull ○Aching ○Burning ○Numb
○Throbbing ○Radiating ○Deep ○Other_____

Rate the pain on a scale of 1-10 (10 being unbearable pain):
Right Now 1----2----3----4----5----6----7----8----9----10
At Its Worst 1----2----3----4----5----6----7----8----9----10

[Mark your areas of concern on figure]



Other Doctors Seen For This Condition: ○Yes ○No Who? _____

Type of treatment? _____ Results? _____

Do you have any other health concerns (even if seems unrelated to chiropractic)?

_____

What medical or lab test have you have done in the last 3 years? _____

_____

DO YOU EXPERIENCE ANY OF THE FOLLOWING

○Headaches	○Digestive trouble	○Tension	○Depression	○Fatigue
○Light bothers eye	○Numbness	○Anxiety	○Chronic pain	○Allergies
○Irritability	○Chronic ill health	○Loss of memory	○Low immunity	○Sleeping problems

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

Musculoskeletal Code
○General Stiffness
○General Weakness
○Swollen/achy Joints
○Spinal Curvature
○Neck Pain
○Arm Pain
○Pain Between Shoulders
○Low Back Pain
○Foot Trouble
○Jaw Problems

Nervous System Code
○Nervous
○Clumsy
○Dizziness
○Forgetfulness
○Depression
○Cold/Tingling Extremities
○Stress
○Twitching
○Can't concentrate
○Difficulty with speech
○Can't remember words

General Code
○Weight Loss/gain
○Hormone issues
○Thyroid Problems
○Head Injury
○Need caffeine to function
○High/low blood sugar
○Lack of Saliva
○Hot/cold
○Arthritis
○Anemia
○Skin condition

Gastrointestinal Code
○ Gas/Bloating/Belching
○Abdominal Cramps
○Heartburn/acid reflux
○Poor/Excessive Appetite
○Excessive Thirst
○Candida
○Nausea
○Diarrhea
○Constipation
○Gall Bladder Problems
○Black/Bloody Stools
○Colitis/ IBS

C-V-R Code
○Chest Pain
○Shortnes Breath
○High Blood Pressure ○ Low Blood Pressure
○Irregular Heartbeat
○Heart Problems
○Lung Problems
○Varicose Veins
○Ankle Swelling
○Stroke
○Pneumonia
○High Cholesterol

Immune System Code
○Feeling feverish
○Sore throat
○Stuffed Nose
○Frequent Colds
○Sinus Trouble
○Hoarseness
○Asthma
○Achy joints

Genitourinary Code
○Bladder Trouble
○Painful/Excessive Urine
○Frequent Urination
○Difficult Urination

For Women Only
○Cramps
○Irregular Cycle
○Painful Periods
○PMS
○Pregnant (now)
○Infertility
○Heavy bleeding
○Fibroids
○Peri-menopause
○Menopause

○Other_____

HEALTH HABITS

Exercise/Sports/Hobbies:
1)Type _____ Frequency _____ 2)Type _____ Frequency _____
3)Type _____ Frequency _____ 4)Type _____ Frequency _____

Sleep: Hours/night ___ Sleep quality _____ Do you sleep on your: ○Back ○Side ○Stomach

Smoking/Drinking/Diet: (how much and how often)
Tea/Coffee _____ Liquor/Beer _____ Cigarettes/Tobacco _____

FAMILY HISTORY

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

PAST HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type _____ When _____

Type _____ When _____

Type _____ When _____

Please list ALL previous accidents and falls emotional traumas (not listed above)

What _____ When _____

What _____ When _____

What _____ When _____

Please list ALL medications and/or vitamins you take

Name_____ For What_____ Name_____ For What_____

Name_____ For What_____ Name_____ For What_____

Name_____ For What_____ Name_____ For What_____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐*Relief Care*

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

☐*Corrective Care*

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

☐Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT ○Cash ○Check ○Credit/Debit (Visa/ MC)

Office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If insurance benefits are verified, I authorize release of my records to my insurance company.

I understand that the services provided by Quantum Healing Arts are intended to enhance my wellbeing. I understand the practitioners work with the body's ability to heal itself and do not diagnose or treat disease. I understand these methods are not a substitute for medicine.

Signature _____ Date _____