Future practice member,

Please fill these next 4 pages out in full and bring with you to your first appointment. Please remember this appointment may take up to 90 minutes as our evaluation is very thorough and we want to give ample time to answer any questions you may have. We are so excited to see you and to see all of the improvements you will have under principled neurologically-based chiropractic care. What you are about to experience will be a whole new take on health care. We can't wait to get started!

Yours in health,

Dr. Malaki Bolton & The Epic Connection Chiropractic Team

Epic Connection Chiropractic
www.goepicconnection.com
(918) 921-4247
1344 E. Hillside Dr.
Broken Arrow, OK. 74012

T 1 2 3

EPIC CONNECTION CHIROPRACTIC HEALTH PROFILE

Name_____**Date**____/____/____**Age**_____**Male/Female**

Address_____**City**_____**State**_____**Zip**_____

Phone: Home_____**Cell**_____**Date of Birth**_____/_____/_____

Email Address_____

For confirming appts, would you prefer? TEXT (cell carrier:_____) or EMAIL

Occupation_____**Employer's Name** _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____**Names, Ages & Gender**_____

_____

Who may we thank for referringyou? _____

***CIRCLE* ALL CURRENT PROBLEMS YOU HAVE**

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*GASTRIC REFULX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	*ALLERGIES*
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER*_____
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	_____
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*	_____	_____
CHRONIC SINUS	*BLADDER PROBLEMS*	*KNEE PAIN*	_____	_____

LIST YOUR TOP 5 HEALTH PROBLEMS

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

***CIRCLE* ANY CONDITION YOU HAVE NOW/ HAVE HAD:**

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

T 1 2 3

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____ MEDICAL DOCTOR?_____ OTHER_____

WHO AND WHEN?_____

LIST ALL SURGICAL OPERATIONS AND YEAR _____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

ANY AUTO ACCIDENTS: Year Speed (MPH) Rear-ended? T-Boned?

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:_____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. MALAKI BOLTON AND ANY AND ALL EPIC CONNECTION CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS (Doctor only) TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY EPIC CONNECTION CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

T 1 2 3

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name_____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 (1) 2 3 (4) 5 6 (7) 8 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

T 1 2 3

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

THANK YOU! THERE ARE ONLY A FEW MORE PAGES WHEN YOU GET TO THE OFFICE. WE ARE SO EXCITED TO **SERVE** YOU! PLEASE FEEL FREE TO BRING ANY FRIENDS/FAMILY WITH YOU.