

**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](http://www.goepicconnection.com)**

**(918) 921-4247**

**1344 E. Hillside Dr.**

**Broken Arrow, OK. 74012**



**EPIC CONNECTION  
CHIROPRACTIC**

◆◆ est. 2017 ◆◆

## 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 referring you? \_\_\_\_\_

### CIRCLE ALL CURRENT PROBLEMS YOU HAVE

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

### LIST YOUR TOP 5 HEALTH PROBLEMS 2017 ♦♦

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 \_\_\_\_\_

### 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:**



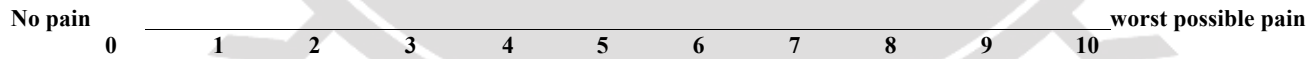
**1 – What is your pain RIGHTNOW?**



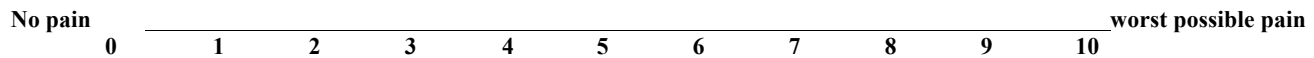
**2 – What is your TYPICAL or AVERAGE pain?**



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



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



**OTHER COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

Examiner \_\_\_\_\_

## 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.