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
1205 N. Birch Ave.
Broken Arrow, OK. 74012

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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	*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

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:____

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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 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

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Scien

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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					

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