# CONFIDENTIAL HEALTH INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards.
Date_____

Full Name_____
Address_____City_____State____Zip_____
Home Phone_____ Cell Phone _____Cell Phone Carrier_____
E-mail_____

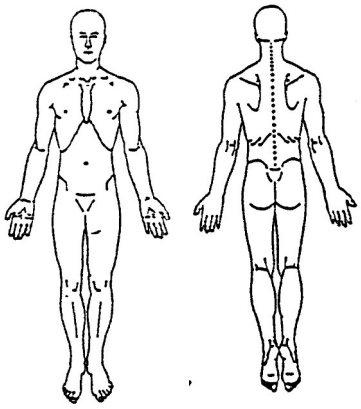
Gender: □ Male □ Female Date of Birth_____ Age_____
Marital Status: □ Single □Married □Widowed □Divorced □ Civil Union □ Partnered
Number of Children_____

Employer_____Occupation_____Phone_____
Nature of Work ○Sitting ○Standing ○Light Labor ○Heavy Labor ○High Stress

Emergency Contact_____ Phone_____

How did you hear about our office? _____
Have you ever received chiropractic care? Y N If yes, when?_____
Most recent Doctor of Chiropractic _____ Name of Primary Care Physician?
_____ Name of his/her practice_____
May we contact/send progress notes to your Primary Care Physician? Y N

**Presenting Illness**



Additional Doctor's Notes for Current Condition

Any loss of Bowel or Bladder function?
Any new medications or change in dose or brand with onset of symptoms?
Any dizziness, tunnel vision, other changes in vision, hearing, smell or taste, speech?
Any chest pains or tightness or heart burn type symptoms especially upon exertion?

Please mark area(s) of concern above.

1. **Reasons for seeking chiropractic care:**

Primary Area of Complaint:_____
Secondary Area of Complaint:_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____
_____
_____





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**3. Details for Reasons for Care**

Primary Area of Complaint _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- What makes the symptom worse? (circle all that apply):
  - Bending, rotation, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Secondary Area of Complaint _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- What makes the symptom worse? (circle all that apply):
  - Bending, rotation, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

(If you have more than two reasons for care, additional worksheets are available when you arrive at our office.)
Doctors Notes:



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**Past Personal, Family, and Social History**

1. **Past Health History:**

**A. Please indicate if you have a history of any of the following:**

□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

**B. Previous Injury or Trauma:**

_____

**Have you ever broken any bones? Which?**

_____

**C. Allergies:** _____

**D. Medications:**

Medication Reason for taking

_____
_____
_____
_____

**E. Surgeries:**

Date Type of Surgery

_____ _____
_____
_____ _____
_____

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery Outcome

_____ _____
_____
_____ _____
_____

2. **Family Health History:**

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Cause of parents or siblings death Age at death

_____
_____
_____
_____

**Social and Occupational History:**

**A. Job description:** _____



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**B. Work schedule:** _____

**C. Recreational activities:**

_____

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

_____

**Review of Systems**

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ ***None of the above***

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ ***None of the above***

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ ***None of the above***

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ ***None of the above***

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ ***None of the above***

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ ***None of the above***

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ ***None of the above***

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ ***None of the above***

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ ***None of the above***

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ ***None of the above***

Is there anything else in your past medical history that you feel is important to your care here? _____





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## Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement sign below in agreement.

**1. By signing below I indicate of have read the explanations below and have had my questions answered to my satisfaction. I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

**The nature of the chiropractic adjustment.**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause and audible "pop", or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis/Examination/Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, basic neurological testing.

**The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

2. I may request a copy of the HIPPA Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

3. I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

4. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

5. To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date

_____ _____

Doctor's signature that this document was reviewed in full Date



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