

PATIENT HEALTH HISTORY

NEW PATIENT
 REACTIVATE (1YEAR)

TODAY'S DATE: _____

PERSONAL INFORMATION

NAME:		HOME PHONE:
STREET ADDRESS:		WORK PHONE:
CITY/STATE/ZIP:		CELL PHONE:
SOCIAL SECURITY #:		DATE OF BIRTH:
DRIVER'S LICENSE#:	EMAIL:	
EMERGENCY CONTACT:	EMERGENCY CONTACT'S PHONE:	

SOCIAL HEALTH HISTORY

STATUS: MALE FEMALE SINGLE MARRIED OTHER: _____ STUDENT: FULL-TIME PART-TIME

OCCUPATION: _____ EMPLOYER: _____

WORK HOURS PER WEEK: _____ RECREATIONAL ACTIVITIES (HOBBIES): _____

YES NO DO YOU COMMUTE TO WORK? HOW FAR? _____

YES NO DO YOU EXERCISE? TIMES PER _____

YES NO ARE YOU A SMOKER? PACKS PER DAY? _____

YES NO DO YOU CONSUME CAFFEINE? HOW MUCH PER DAY? _____

YES NO DO YOU CONSUME ALCOHOL? GLASSES PER DAY / WEEK? _____

SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

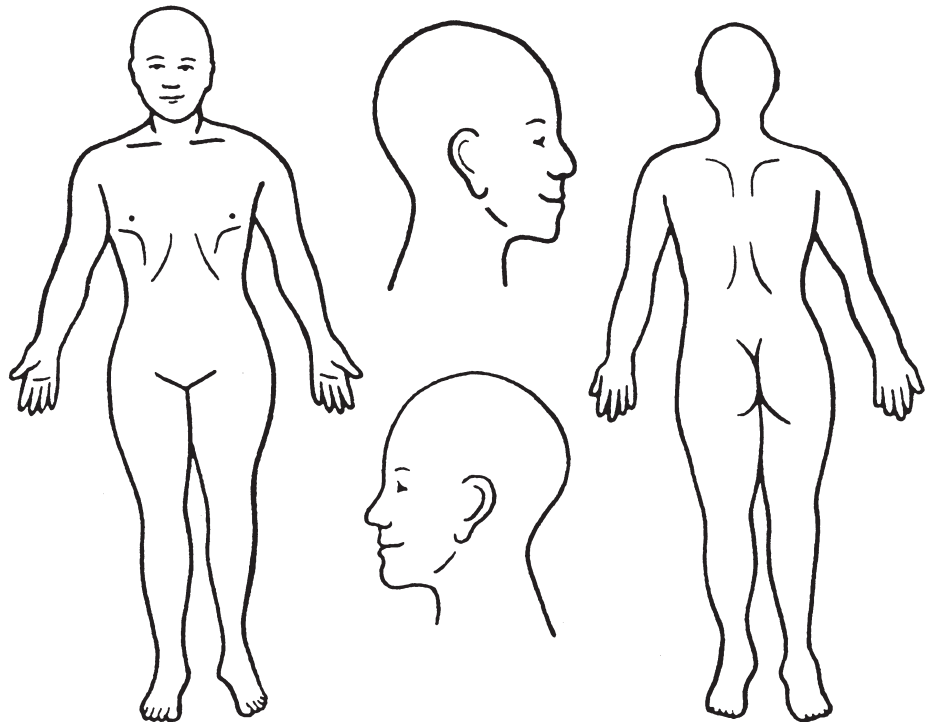
NAMES / AGES OF CHILDREN AT HOME: _____ SPOUSE'S DOB: _____

WHO IS YOUR MEDICAL DOCTOR? _____ MEDICAL DOCTOR CITY / STATE: _____

CHIEF COMPLAINT

BE SURE TO FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION. USE THE APPROPRIATE SYMBOLS. IF THERE IS MORE THAN ONE AREA OF DISCOMFORT, PLEASE RATE THE PAIN ON A SCALE OF 0 TO 100 NEXT TO EACH ARE, WITH 0 BEING NO PAIN AND 100 BEING INTOLERABLE PAIN.

- XXX BURNING (BU)
- ((((ACHING PAIN (AC)
- 000 PINS & NEEDLES (PI)
- - - NUMBNESS (NU)
- ::: SHARP PAINS (SH)



SYMPTOMS DEVELOPED FROM:

WORK-RELATED INJURY

AUTO ACCIDENT

OTHER

1. WHEN DID THEY BEGIN? _____
2. WHAT IS YOUR MAJOR SYMPTOM? _____
3. WHAT DOES THIS PREVENT YOU FROM DOING OR ENJOYING? _____

4. IF THIS IS A RECURRENCE, WHEN WAS THE FIRST TIME YOU NOTICED THIS PROBLEM? _____
HOW DID IT ORIGINALLY OCCUR? _____
HAS IT BECOME WORSE RECENTLY? YES___ NO___ SAME___ BETTER___ GRADUALLY WORSE___
IF YES, WHEN AND HOW? _____
5. HOW FREQUENT IS THE CONDITION? CONSTANT___ DAILY___ INTERMITTENT___ NIGHT ONLY___
HOW LONG DOES IT LAST? ALL DAY___ FEW HOURS___ MINUTES___
6. ARE THERE ANY OTHER CONDITIONS OR SYMPTOMS THAT MAY BE RELATED TO YOUR MAJOR SYMPTOM?
YES___ NO___ . IF YES, DESCRIBE _____
7. IS THERE ANYTHING YOU CAN DO TO RELIEVE THE PROBLEM? YES___ NO___ . IF YES, DESCRIBE _____
_____. IF NO, WHAT HAVE YOU TRIED TO DO THAT HAS NOT HELPED? _____

8. WHAT MAKES THE PROBLEM WORSE? STANDING___ SITTING___ LYING___ BENDING___ LIFTING___ TWISTING___
OTHER _____
9. DOES THE PAIN INTERFERE WITH YOUR SLEEP? YES___ NO___ . HOW MANY TIMES DO YOU WAKE UP? _____
10. DO YOU SLEEP WITH A PILLOW? YES___ NO___ . IF SO, HOW MANY?___ WHAT POSITION DO YOU SLEEP IN? _____
11. DOES HEAT AFFECT THE PAIN? YES___ NO___ . HOW? _____
12. DOES COLD AFFECT THE PAIN? YES___ NO___ . HOW? _____
13. DO YOU WEAR A HEEL LIFT? YES___ NO___ . IF SO, WHICH SIDE? _____
14. **HEADACHES - DO YOU EXPERIENCE:** NOT APPLICABLE
NAUSEA, VOMITING, OR VISUAL DISTURBANCES? YES___ NO___
PAIN OR CRACKING IN JAW? YES___ NO___
ABNORMAL BLOOD PRESSURE? YES___ NO___
FAMILY HISTORY OF HEADACHES? YES___ NO___
FREQUENCY OF HEADACHES: _____ EYE EXAM DATE: _____
15. **CERVICAL SPINE (NECK):** NOT APPLICABLE
NECK INJURY THAT AFFECTS HEARING? YES___ NO___
VISION, BALANCE, OR RINGING IN EARS? YES___ NO___
DO YOU HEAR GRATING SOUNDS? YES___ NO___
FAMILY HISTORY OF HEADACHES? YES___ NO___
DIFFICULTY TURNING HEAD? RIGHT___ LEFT___
PAIN / PRESSURE BEHIND EYES? YES___ NO___
FEELING OF RIPPING OR TEARING? YES___ NO___ . WHERE: _____
16. **LUMBOSACRAL SPINE (LOW BACK):** NOT APPLICABLE
FEELING OF RIPPING OR TEARING? YES___ NO___ . WHERE: _____
DOES PAIN RADIATE TO THE ABDOMEN? YES___ NO___
IMPAIRMENT OF BOWEL OR URINARY FUNCTION? YES___ NO___ . EXPLAIN: _____
17. HAVE YOU HAD ANY BROKEN BONES? YES___ NO___ . IF YES, PLEASE LIST AND GIVE DATES _____

18. **WOMEN ONLY:** ARE YOU PREGNANT OR IS THERE ANY POSSIBILITY YOU MAY BE PREGNANT? YES___ NO___ UNCERTAIN___

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES OR N FOR NO IN EACH OF THE FOLLOWING:)

- | | | |
|----------------------------------|-----------------------|-------------------------|
| 1. ___ EYES | 6. ___ URINARY | 11. ___ INTERNAL ORGANS |
| 2. ___ EARS, NOSE, MOUTH, THROAT | 7. ___ MUSCLES | 12. ___ BLOOD |
| 3. ___ HEART | 8. ___ NERVES | 13. ___ ALLERGIES |
| 4. ___ LUNGS/BREATHING | 9. ___ SKIN | 14. ___ OTHER _____ |
| 5. ___ INTESTINES | 10. ___ PSYCHOLOGICAL | |

PLEASE DESCRIBE: _____

ADDITIONAL COMMENTS: _____

PAST MEDICAL HISTORY

HOW MANY TIMES HAVE YOU HAD THE CONDITION THAT YOU ARE SEEING US FOR TODAY? 0-3 TIMES 4 OR MORE TIMES

YES NO DO YOU SUFFER FROM ANY CONDITION OTHER THAN THAT FOR WHICH YOU ARE NOW CONSULTING US?
(DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, ETC.) IF YES, WHAT? _____

YES NO HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?

DATE	DR. NAME	CONDITION	RESULTS
1.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS
2.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS

YES NO HAVE YOU EVER SEEN A DOCTOR FOR THIS CONDITION?

DATE	DR. NAME	CONDITION	RESULTS
1.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS
2.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS

YES NO ALLERGIES? TO WHAT? _____

YES NO DO YOU NOW TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT / DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
1.				
2.				
3.				

YES NO HAVE YOU EVER HAD MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS, OR SURGERIES?

DATE	DR. NAME	CONDITION	RESULTS
1.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS
2.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS
3.			<input type="checkbox"/> COMPLETE RECOVER <input type="checkbox"/> COMPLICATIONS

FAMILY HEALTH HISTORY

HEALTH STATUS OF FAMILY MEMBERS. (IF DECEASED, FROM WHAT?)

MOTHER: _____

FATHER: _____

SISTERS: _____ HOW MANY? _____

BROTHERS: _____ HOW MANY? _____

CHILDREN: _____ HOW MANY? _____

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT IS SO APPROVED.

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

D.C./C.A. SIGNATURE: _____ DATE: _____

INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFOR IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULL INFORMED IN CONSENTING TO TREATMENT.

CHIROPRACTIC OFFICES USE TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTION, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE- STROKE IS THE MOST SERIOUS COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY A CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN OCCURS, MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHING THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT 1 PER 400,000 TREATMENTS TO 1 TO 5.85 MILLION TREATMENTS. (CMAJ 2001 OCT. 2; 165 (7):905-6). THE ANNUAL INCIDENCE OF A SPONTANEOUS STROKE IS ESTIMATED AT 1 TO 1.5 PER 100,000 (NEJM, 1994; 330:339-397). THE RESULTS OF A RETROSPECTIVE STUDY CONDUCTED BY HALDEMAN S, ET. AL, SUGGESTED THAT STROKE SHOULD BE CONSIDERED A RANDOM AND UNPREDICTABLE COMPLICATION OF ANY NECK MOVEMENT INCLUDING CERVICAL MANIPULATION (J NEUROL 2002 Aug; 249(8): 1098-104).

SORENESS- CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IS IS NOT GENERAL DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY- OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY- MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES CONSIDERED AT RISK. TREATMENT IS PERFORMED CAREFULLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS- HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS- THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS YOUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

PATIENT'S NAME PRINTED

TODAY'S DATE

PATIENT'S SIGNATURE

PARENT OF GUARDIAN SIGNATURE FOR MINOR
