# Patient History (Please Print) Date:_____

Name: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Birth Date: _____ ☐Male ☐Female Spouse's Name: _____

Children #_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Driver's License # _____

Occupation _____ Social Security# : _____

How were you referred to the Office? _____

Have you ever been under chiropractic care before? _____ If yes, when? _____

**INFORMATION ABOUT THE ACCIDENT/PRESENT INJURY:**

Please explain in detail how your accident happened: _____

_____

_____

_____

Were you knocked unconscious? ☐ Yes ☐ No You were struck from: ☐ Behind ☐ Front ☐ Left ☐ Right

You were: ☐ Driver ☐ Passenger ☐ Back seat- left ☐ Back seat - right ☐ Using seat belts

What was the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

_____

Were you hospitalized? ☐ Yes ☐ No If hospitalized, were you admitted? ☐ Yes ☐ No For how long?_____

What treatment was given? _____

Was any doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ What was the diagnosis? _____

What treatment was given? _____

What How frequently did you see the doctor? _____ How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

**INSURANCE INFORMATION:**

Driver of other vehicle (if any):

Full name: _____ Ins. Company: _____ Claim No. _____

Driver of vehicle in which you were injured (if any):

Full name: _____ Ins. Company: _____ Claim No. _____

Name of your insurance adjustor: _____ Adjustor fax number: _____

Adjustor phone number or email: _____

Have you retained an attorney? ☐ Yes ☐ No If yes, what is their name? _____

If so, what is their email or phone#? _____ Fax number? _____

**List your chief complaints in order of severity: Check all those that describe your condition:**

**Complaint 1:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐ Burning

☐Other: _____

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

It has been: ☐ Getting worse ☐ Staying the same ☐ Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During the Day it is: ☐ Worse in the AM ☐ Worse in the PM ☐ Stays the same throughout the day

The following **increases** pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other _____

The following **decreases** the pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other _____

Does the pain travel/radiate? ☐ Yes ☐ No If yes, where? _____

**Complaint 2:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐ Burning

☐Other: _____

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

It has been: ☐ Getting worse ☐ Staying the same ☐ Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During the Day it is: ☐ Worse in the AM ☐ Worse in the PM ☐ Stays the same throughout the day

The following **increases** pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other _____

The following **decreases** the pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other _____

Does the pain travel/radiate? ☐ Yes ☐ No If yes, where? _____

**Complaint 3:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐ Burning

☐Other: _____

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

It has been: ☐ Getting worse ☐ Staying the same ☐ Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During the Day it is: ☐ Worse in the AM ☐ Worse in the PM ☐ Stays the same throughout the day

The following **increases** pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other _____

The following **decreases** the pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other _____

Does the pain travel/radiate? ☐ Yes ☐ No If yes, where? _____

List of previous hospital stays/surgeries (what and when?)

_____

_____

List of any childhood/adult traumas/accidents/falls/auto injuries (what happened and when?)

_____

_____

_____

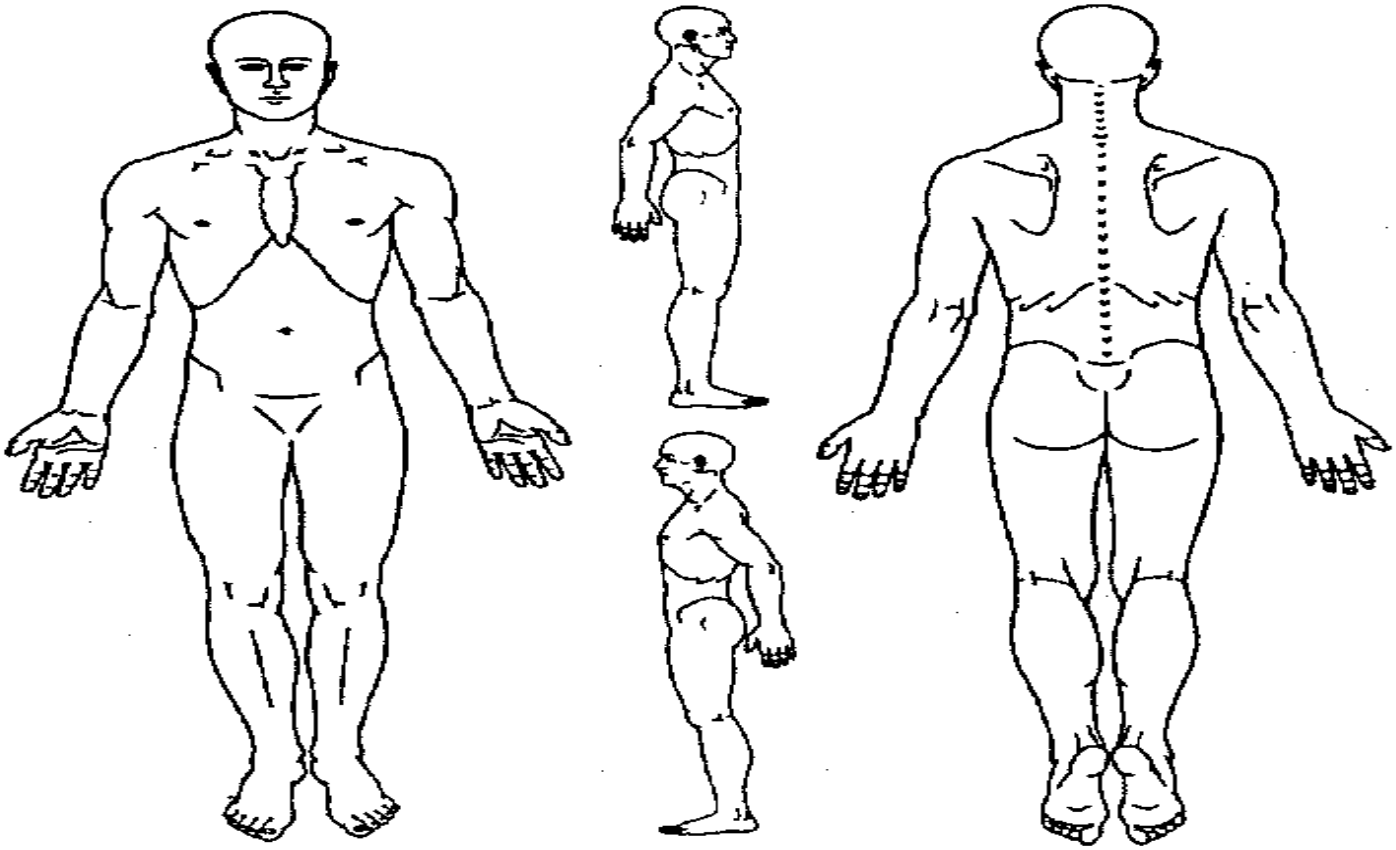
_____

Is there anything else you think we should know about you or that you would like to discuss (explain)

_____

_____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels.



Does your condition interfere with your:

| | | | | | Goals for Care : |
|---|---|---|---|---|---|
| Work | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE | _____ |
| Sleep | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE | _____ |
| Daily Routine | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE | _____ |
| Recreation | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE | _____ |

Does your condition interfere with any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Computer use | ☐ Sports | ☐ Reading | ☐ Exercise | ☐ Vacuuming | ☐ Social Life |
| ☐ Cleaning | ☐ Cooking | ☐ Watching Kids | ☐ Yard Work | ☐ Driving | ☐ Relationship |
| ☐ Shopping | ☐ Gardening | ☐ School | ☐ Self Care | ☐ Other _____ | |

Do you suffer from any of the following conditions currently?

| | | | |
|---|---|---|---|
| ☐ Abdominal aortic aneurysm | ☐ AIDS/HIV | ☐ Allergy Shots | ☐ Asthma |
| ☐ Alcoholism/Drug Abuse | ☐ Arthritis | ☐ Anemia | ☐ Auto immune |
| ☐ Anxiety/Depression | ☐ Appendicitis | ☐ Anorexia | ☐ Allergy Shots |
| ☐ Bleeding Disorders | ☐ Bulimia | ☐ Buzzing/ringing in ears | ☐ Cancer |
| ☐ Chemical Dependency | ☐ Cataracts | ☐ Chicken pox | ☐ Chronic Fatigue |
| ☐ Cold hands/feet | ☐ Constipation | ☐ Coronary artery disease | ☐ Diabetes |
| ☐ Digestive problems | ☐ Diarrhea | ☐ Dysmenorrhea | ☐ Eczema |
| ☐ Erectile Dysfunction | ☐ Emphysema | ☐ Eye Troubles | ☐ Neck pain |
| ☐ Fractures | ☐ Gas/Bloating | ☐ Glaucoma | ☐ Goiter |
| ☐ Gonorrhea | ☐ Gout | ☐ Heart disease | ☐ Headaches |
| ☐ Hepatitis | ☐ Hernia | ☐ Herniated Disc | ☐ Herpes |
| ☐ High cholesterol | ☐ Indigestion | ☐ Hypertension/HBP | ☐ Kidney disease |
| ☐ Kidney stones | ☐ Liver disease | ☐ Loss of balance | ☐ Loss of sleep |
| ☐ Low back pain | ☐ Measles | ☐ Menstrual problems | ☐ Miscarriage |
| ☐ Mid back pain | ☐ Mononucleosis | ☐ Multiple sclerosis | ☐ Mumps |
| ☐ Osteoporosis | ☐ Pacemaker | ☐ Parkinson's | ☐ Pneumonia |
| ☐ Pain/Tingling/Numbness in arms/legs/hands | | ☐ Prostate problems | ☐ Psychiatric care |
| ☐ Rheumatoid arthritis | ☐ Sinus problems | ☐ Shortness of breath | ☐ Shingles |
| ☐ Throat conditions | ☐ Suicide attempt | ☐ Swollen ankles | ☐ Stroke |
| ☐ Thyroid conditions | ☐ Tuberculosis | ☐ Tumors/growth | ☐ Typhoid fever |
| ☐ Unexplained weight gain | ☐ Unexplained memory loss | | ☐ UTI |
| ☐ Unexplained weight loss | ☐ Ulcers/colitis/IBS | ☐ Vaginal Infection | ☐ STI |
| ☐ Whooping cough | ☐ Other _____ | | |

**Family History (please list all known conditions/illnesses that may apply):**

Mother: _____ Father: _____
Grandparents: _____ Siblings: _____

Other known familial conditions:

_____

_____

**For Women only:**

Are you Pregnant? ☐ Yes ☐ No Due Date: _____
Are you Nursing? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No
Do you have regular cycles? ☐ Yes ☐ No Do you have breast implants?: ☐ Yes ☐ No
Do you experience painful periods? ☐ Yes ☐ No

**COVID-19 QUESTIONNAIRE:**

Have you been vaccinated? _____

If yes, which vaccine did you receive and when? _____

Did you notice any side effects? _____

Have you received any boosters? _____

If yes, which boosters did you receive and when?_____

Did you notice any side effects? _____

Have you had COVID? _____ How many times? _____ When was the last time you had COVID? _____

Have you had any long-term complaints associated with COVID? (please explain) _____

_____

_____

**HEALTH HEABITS:**

Do you smoke/vape? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Do you eat organic food? ☐ Yes ☐ No Do you drink soda? ☐ Yes ☐ No

Do you eat processed food? ☐ None ☐ Some ☐ Moderate

**CONCERNS:** We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and **circle your top 3**

| | | |
|---|---|---|
| Is it going to hurt? | Is it expensive? | What do I do if chiropractic does not work? |
| Do I have to come forever? | Are the X-rays dangerous? | What if insurance does not cover chiropractic? |
| Can this be fixed? | Is it addictive? | I don't want to be cracked |

**STRENGTHS:** Strong habits are key to health: It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and **circle your top 3**

| | | |
|---|---|---|
| Stretch 3-5 times a week | Exercise 3-5 times a week | Drink ½ my body weight of ounces of water |
| Take supplements for health | Do activities to minimize stress regularly | Drink or eat something green everyday |
| Have a positive attitude | Sleep 6-8 hours a night | Get maintenance chiropractic 2-4 x/year |
| Pray/meditate | Non-smoker | Get maintenance chiropractic 4-8x/year |

**GOALS:** We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant **circle your top 3**

| | | |
|---|---|---|
| Sleep through the night | Continue working/get back to work | Play with kids/grandkids normally |
| Exercise again | Avoid future flare ups | Sit/Stand comfortably for an extended period |
| Get off pain medications | Be ready for an upcoming event | Have some moments of relief |
| Have a better attitude | Additional Goals: _____ | |

People see Chiropractors for a variety of reasons. Some go in for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

**Type of Care:**

☐ Relief Care: Symptomatic relief of pain or discomfort

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

## Authorization for Care and Notice of Privacy

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered. This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception

**Patient's Signature:** _____ **Date:** _____

**Printed Name:** _____

# Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits risks and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and /or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctors will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual finding, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not usual, however, you may be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects: i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke, which occurs at a rate between once per one million to one per two million.

**Other side effects may include healthier lifestyles, more smiling, increased activity, deeper breathing and feeling younger.**

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

**Patient's Signature:** _____ **Date:** _____

**Printed Name:** _____