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WELCOME!

Patient: PLEASE PRINT

Name(First)_____(M.I.)_____(Last)_____
Gender: M F Birthdate ____/____/____ Age:_____
Are you: ☐ Single ☐ Married ☐ Domestic Partner
Do you have kids? ☐ No ☐ Yes Names and ages:_____
Home Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____
Work Phone_____ Ext._____
E-mail Address _____
Employer Name_____ Occupation_____
Job Functions / Work Environment _____
Employer Address_____
Whom may we THANK for referring you to us?_____

Spouse, Guardian or Partner (if applicable):

Name_____
Employer Name_____ Work Phone_____
Date of Birth ___/___/ ___ Occupation _____

Emergency: (Name and address of nearest relative or friend not living with you)

Name_____ Relation to Patient_____
Home Phone _____ Work phone_____
Address_____

My Account Will Be Handled By:

☐ Self Pay ☐ Blue Cross Blue Shield ☐ Personal Injury ☐ Medicare

We bill to BCBS and Medicare only. All other insurance plans will be considered self pay and you may send receipt to your insurance carrier.

Responsible Party: (Complete this section if you are not the patient but are responsible for the bill, such as parent or guardian)

Responsible Person_____ Relation to Patient _____
Address_____ Apt #_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Employer Name_____ Occupation_____

Integrated Chiropractic Wellness PLLC

Case History

Patient Name_____ Date_____

Please list your major health problems/concerns and when you first noticed them:

1. _____
2. _____
3. _____
4. _____

If your condition involves pain, please characterize type and draw:

□Ache □Sharp □Radiating □Constant □Intermittent

Any other comments:

What makes it worse:

_____

_____

What makes it better:

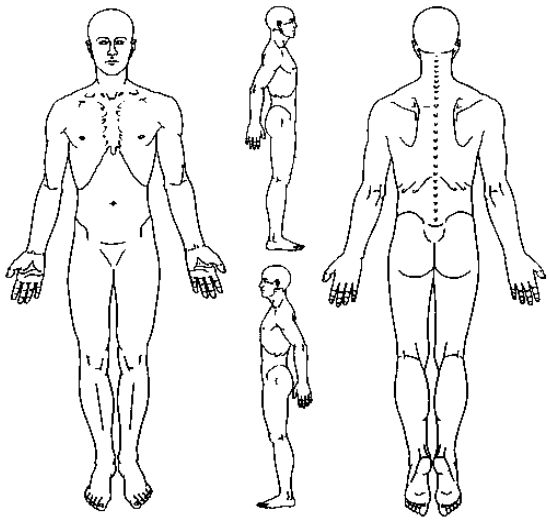
_____

_____

_____

0 10

☺ Pain Scale ☹



Please <u>underline</u> any conditions you have had in the past and circle any you currently have.

AIDS	Congestive Heart Failure	HIV positive	Psychiatric care
Alcoholism	Depression	Joint replacement	Rheumatic Fever
Anemia	Diabetes	Kidney Disease	Rheumatoid arthritis
Anorexia	Eczema	Liver Disease	Scarlet fever
Anxiety	Emphysema	Measles	Sexually transmitted disease
Appendicitis	Epilepsy	Migraines	Sinus Problems
Arthritis	Glaucoma	Miscarriage	Stroke
Asthma	Gonorrhea	Mononucleosis	Suicide thoughts/attempt
Bleeding Disorders	Gout	Multiple Sclerosis	Thyroid problems
Blood in urine	High blood pressure	Mumps	Tonsillitis
Breast Lump	Heart murmur	Panic Attacks	Tuberculosis
Bronchitis	Hepatitis	Pacemaker	Ulcers
Bulemia	Hernia	Pneumonia	Unconsciousness
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	Hiatal Hernia	Post Partum Blues	Other:
Coma	High Cholesterol	Psoriasis	

Please list and date ANY:

Surgeries/ Procedures:_____

Accidents/ Serious Injuries:_____

_____

Broken Bones/ Dislocations:_____

Have you ever had ☐ spinal x-rays ☐ MRI ☐ CT For what?_____

Current Family Physician:_____Phone_____

Medications (purpose) / Herbs / Supplements (please include brand)

_____ _____ _____

_____ _____ _____

Work Habits: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor _____

Do You Smoke? ☐ No ☐ Yes Packs/ Day_____

Amount of water you drink each day_____ Your weight _____lbs Your height_____

Review of Systems

Please underline any conditions you have had in the past and circle any you currently have.

General	Cardiac/vascular	GU	Cold intolerance
Fever	Chest pain	Bladder control	Hair falling out
Chills	Chest pressure	Blood in urine	Excessive thirst
Night Sweats	Fainting	Decrease force or urine	Heme/lymph
Weight Loss	Heart murmur	Painful intercourse	Easy bruising
Fatigue	High blood pressure	Painful urination	Bleeding gums
Loss of energy	Irregular heart beat	Pelvic pain	Lymph nodes
Loss of sleep	Leg pain when walk	Sexual dysfunction	Allergies/Immun
Eye	Lightheaded	Urinary hesitancy	Seasonal allergies
Blurred vision	Low blood pressure	Neurology	Other allergies
Double vision	Pass out	Cold or numb hands/feet	
Crossed-lazy eye(s)	Palpitations	Convulsions (seizures)	
Eye pain	Phlebitis	Frequent headaches	
Loss of vision	Poor circulation	Muscle weakness	
Visual Flashes	Shortness of breath	Numbness/tingling	
Visual Halos	At rest	Tremors	
Had laser surgeries	With exertion	Unsteady walking	Female only
Wear glasses or contacts	Lying flat	Vertigo/spinning	# of pregnancies:
Ear, Nose, Throat	Swollen ankles	Psychosocial	# of live births:
Decreased hearing	Varicose Veins	Anxiety	# of miscarriages/abortions:
Earache	Pulmonary	Depression	# vaginal deliveries :
Ear discharge	Cough	Nervousness	
Ear fullness	Wheezing	Skin/breast	
Ear infections	Gastrointestinal	Eczema	
Ear ringing-buzzing	Abdominal pain	Hives	
Hoarseness (prolonged)	Black stools	Itching	
Jaw Clicking	Bloating	Rashes	Painful
Jaw locking	Blood in stools	Yellow skin/eyes	
Nosebleeds	Constipation	Breast lumps	Pregnant Now?
Post nasal drip	Diarrhea	Nipple discharge	Nursing?
Sinus problems	Heartburn	**Endocrine**	
Sore throat (frequent)	Hemorrhoids	Excessive weight gain	
Swallowing difficulty	Nausea	Excessive weight loss	

Other symptoms not covered:

1. Have you been treated by a chiropractor in the past? Yes / No
2. Did you have a good experience? Please explain to us what you liked or what you did not like:

_____

_____

3. When was your last adjustment:

_____

4. How long were you under care?

_____

TREATMENT: What type of treatment are you looking for?

____ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
____ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
____ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

Habits: Please mark the box in the area of the spectrum where you would find yourself most days.

Drink > 5 glasses water/day	□	□	□	□	□	□	□	Drink coffee/ soda/ alcohol
Eat whole foods	□	□	□	□	□	□	□	Eat refined foods, fried foods, hydrogenated fat, same foods
Fresh air in home	□	□	□	□	□	□	□	Unclean air ducts/ mold
Exercise/ Walk up stairs	□	□	□	□	□	□	□	No structured exercise in week
Stretch	□	□	□	□	□	□	□	No stretching / inflexible
Wear supportive shoes	□	□	□	□	□	□	□	Wear heels or non-supportive shoes
Feel rested / sleep on back/side w/ Cervical Pillow	□	□	□	□	□	□	□	Un-rested, sleep on stomach
Do what you enjoy	□	□	□	□	□	□	□	Do what you have to
Quality time w/ family,friend	□	□	□	□	□	□	□	Work all the time
Positive mental attitude/purpose in life	□	□	□	□	□	□	□	Negative, aimless thoughts
Ask yourself difficult questions	□	□	□	□	□	□	□	Avoid internal/ external conflict
Laugh at self	□	□	□	□	□	□	□	Take yourself very serious

I certify that I have answered the above information to the best of my knowledge.

Patient Signature_____Date_____

CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to myself while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments. Those complications may include but may not be limited to: fractures, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. 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. The chiropractic profession has relied on comprehensive research to determine the level of risk associated with chiropractic neck manipulation and there is negligible evidence to support a causal relationship between cervical manipulation and vertebral artery dissection, which can lead to stroke. In fact, scientific studies have shown that neck manipulation (or chiropractic cervical adjustment) is safe, effective and appropriate for patients with common forms of neck pain and headache. An estimate of the odds of suffering a serious complication from a chiropractic neck adjustment are 1 in 5 million cervical manipulations. I do not expect the doctor to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I understand that I will have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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Do not sign until you have read and understood the above.

SIGNATURE _____DATE_____

[Below for children only.]

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

SIGNATURE _____ DATE _____