Confidential Patient Information Sheet

Name _____

Drivers License # _____

Social Security # _____

Address _____

_____ _____

Home Phone _____

Email Address _____

Birthdate _____ _____

Occupation _____

Employer _____

Work Address _____

_____ _____

Work Phone _____

Supervisor _____

Spouse's Name _____

Drivers License # _____

Social Security # _____

Occupation _____

Employer _____

Work Address _____

_____ Zip _____

Work Phone _____

Patient's Nearest Relative _____

Address _____

_____ Zip _____

Phone _____

Marital Status M S W D How Many Children _____

Do you prefer to pay by: Cash _____ Check _____ Credit Card _____

Do you have Health Insurance? Yes No
(if yes, please fill out the attached insurance form enclosed.)

Date _____ Patient # _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

print name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

signature date

PATIENT QUESTIONNAIRE

Name _____ Patient # _____ Date _____

1. What is the purpose of this appointment (major complaint)? _____

_____

2. Is condition due to an injury or fall? ☐ Yes ☐ No

Date of Accident _____ Description _____

_____

3. List number of days missed from work if any. _____

4. Have you ever had this condition or a similar on in the past? ☐ Yes ☐ No

5. Has this condition been treated in the past? ☐ Yes ☐ No

6. List other doctors who have treated this condition. _____

7. What aggravates your condition? _____

_____

8. Is this condition progressively worse? ☐ Yes ☐ No

9. Is this condition ☐ Constant ☐ Periodic

10. Does this condition interfere with your. ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

11. What do you believe is wrong with you? _____

12. How long has it been since you really felt well? _____

13. What type of service do you desire ☐ Temporary relief ☐ Permanent correction (if possible)
☐ Maintenance Care

14. How would you classify your condition? ☐ Minor ☐ Constant ☐ Re-Occurring
☐ Progressively Getting Worse ☐ Serious

15. Have you been treated for any other health condition by a physician in last year? ☐ Yes ☐ No

If yes, please describe: _____

_____

16. List any serious illness: _____

17. List any medications or drugs you are taking: _____

_____

18. Are you Pregnant? ☐ Yes ☐ No

19. List any surgical operations and dates: _____

_____

20. Previous chiropractic care before? ☐ Yes ☐ No

If yes, please list doctors _____

PATIENT HEALTH QUESTIONNAIRE

Name _____ Patient # _____ Date _____

Please Check (X) All Present Symptoms

Cardiovascular

( ) General Swelling
( ) Swelling in Legs
( ) Swelling in Face
( ) Swelling around Eyes
( ) Pounding Heart Beat
( ) Heart "Jumps"
( ) Rapid Heart Beat
( ) Blue or Purple Skin
( ) Fainting
( ) Hypertension

Vertebrobasilar

( ) Double Vision
( ) Loss of Coordination
( ) Irregular Muscle Movement
( ) Ringing in Ears
( ) Heart Attack
( ) High Blood Pressure
( ) Irregular Heart Beat
( ) Hardening of the Arteries
( ) Areas of Muscle Weakness
( ) Dizziness with Nausea
( ) Dizziness without Nausea
( ) Blurred Vision
( ) Fainting Spells
( ) Stroke
( ) Diabetes
( ) Pain over the Heart
( ) Cold Hands and/or Feet
( ) Areas of Numbness
( ) Arthritis of the Neck
( ) Previous Neck or Head Injury
( ) Loss of Memory
( ) Inability to form words (talk plainly)
( ) Periods of blindness in one eye
( ) Areas of Abnormal Sensation - such as burning, etc.
( ) Blood Vessel Disease (phlebitis, etc.)
( ) Check if you Smoke
( ) Check if any of your Family Members Have had a Stroke
( ) Check if you are taking Birth Control Pills

Musculoskeletal System

Head

( ) Unusually Frequent Headache
( ) Unusually Severe Headache
( ) Head Feels Heavy
( ) Vertigo
( ) Light-Headedness
( ) Loss of Smell
( ) Loss of Taste
( ) Loss of Balance
( ) Dizziness

Neck

( ) Pain in Neck
( ) Neck Pain with Movement
( ) Swelling in Neck
( ) Stiff Neck
( ) Pinch Nerve in Neck
( ) Neck feels out of place
( ) Muscle Spasms in Neck
( ) Grinding Sounds in Neck
( ) Limited Neck Movement

Arms & Hands

( ) Pain in Upper Arm
( ) Pain in Forearm
( ) Pain Hands
( ) Pain in Fingers
( ) Sensation of Pins & Needles
( ) In Arms
( ) In Fingers
( ) Fingers go to Sleep
( ) Hands Cold
( ) Swollen Joints in Fingers
( ) Loss of Grip Strength
( ) Sore Joints in Fingers
( ) Loss of Grip Strength

Mid Back

( ) Mid Back Pain
( ) Pain Between Shoulder Blades
( ) Dull Ache
( ) Pain over Kidney Area
( ) Muscle Spasms in Mid Back

PATIENT HEALTH QUESTIONNAIRE Cont.

Name _____ Patient # _____ Date _____

Please Check (X) All Present Symptoms

Musculoskeletal System Cont.

Shoulders

( ) Pain in Shoulders (R - L)
( ) Pain across Shoulders
( ) Tension in Shoulders
( ) Muscle Spasms in Shoulders
( ) Can't Raise Arms
( ) Above Shoulder Level
( ) Over Head

Low Back

( ) Low Back Pain
( ) Low Back Feels out of Place
( ) Muscle Spasms in Low Back

( ) Pain in Buttocks
( ) Pain Down Leg
( ) Knee Pain
( ) Leg Cramps
( ) Pins & Needles in Legs

Hips, Legs, & Feet

( ) Numbness in Legs
( ) Numbness in Toes
( ) Cold Feet
( ) Swollen Ankles
( ) Swollen Feet

General

Skin, Hair, & Nails

( ) Eczema
( ) Itchy Skin
( ) Dry Scalp
( ) Oily Scalp
( ) Rough, Scaly Skin
( ) Dry Skin
( ) Oily Skin
( ) Psoriasis
( ) Yellow skin
( ) Bruise Easily
( ) Paper Thin Nails
( ) Pale Skin
( ) Nail Biting
( ) Baldness

Genitourinary

Urination is ( ) Frequent
( ) Normal
( ) Infrequent

Amount is ( ) High
( ) Normal
( ) Low

( ) Need to get up at night to urinate
( ) Abnormal intense desire to urinate
( ) Decreased Output
( ) Pain on Urination
( ) Dribbling
( ) Blood in Urine
( ) Cloudy Urine
( ) Lack of Bladder Control
( ) Abdominal Pain

Eyes

( ) Blurring of Vision
( ) Double Vision
( ) Eyes Fatigue Easily
( ) Excessive Tearing
( ) Lack of Tearing
( ) Light Bothers Eyes
( ) Excessive Itching
( ) Pain in Eyeball

Venereal Disease

( ) AIDS
( ) Syphilis
( ) Gonorrhea
( ) HIV Positive
( ) Other

Ears

( ) Loss of Hearing
( ) Pain in Ears
( ) Discharge from Ears
( ) Vertigo
( ) Ringing in Ears

Women Only

( ) Painful Period
( ) Spotting
( ) Vaginal Discharge
( ) Premenstrual Symptoms
( ) Irregular Periods
( ) Lumps in Breast

PATIENT HEALTH QUESTIONNAIRE Cont.

Name_____ Patient # _____ Date _____

Please Check (X) All Present Symptoms

Nose, Nasopharynx, & Sinuses

( ) Unusual Nasal Discharge
( ) Nose Bleeds
( ) Pressure Over Eyes
( ) Pressure Under Eyes
( ) Obstruction of Nose
( ) Frequent Colds
( ) Sinusitis
( ) Nasal Allergies
( ) Loss of Sense of Smell
( ) Any Trauma to Nose

Mouth & Throat

( ) Pain in Mouth
( ) Pain in Throat
( ) Bleeding of Gums
( ) Cavities
( ) Abscessed Teeth
( ) Dentures
( ) Difficulty Swallowing
( ) Changes in Voice

Respiratory

( ) Shortness of Breath
( ) Can't Breath while Lying on Side
( ) Can't Sleep while Lying Down
( ) Dry Cough
( ) Productive Cough
( ) Coughing up Blood

Gastrointestinal

( ) Poor Appetite
( ) Constant Nibbling
( ) Difficulty in Swallowing
( ) Indigestion
( ) Can't eat some Foods
( ) Nausea & Vomiting
( ) Jaundice
( ) Abdominal Pain
( ) Change in Bowel Habits
( ) Diarrhea
( ) Constipation

General Cont.

Women Only Cont.

Number of Pregnancies_____

Number of Deliveries _____

Social History

( ) Smoking
Packs/Years_____
( ) Other Tobacco use
( ) Alcohol Use
( ) Recreational Drug Use

Diet is ( ) Balanced ( ) Unbalanced

Rest is ( ) Sufficient ( ) Insufficient

Family Stress ( ) Severe ( ) Moderate ( ) Minimal ( ) None

Work ( ) I love it ( ) It's Okay ( ) I hate it

My Job Stress ( ) Severe ( ) Moderate ( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Generally Feel Run-Down
( ) Crave Sweets
( ) Crave Salts
( ) Crave other