Indian Creek Chiropractic Patient Information

Patient Name:_____ Date:_____ Date of Birth_____ Age_____
Address_____City_____ State _____ Zip Code _____
H. Phone _____W. Phone_____ Cell Phone _____
Email Address: _____ Social Security #_____
Occupation_____ Employer_____
Sex M F Marital Status M S D W Spouse Name:_____ Spouse DOB:_____

Health History:

Recent x-rays or MRI's: Region(s)_____Date(s)_____ Provider(s)_____

Previous Injuries or Traumas: _____

Past conditions:

□ Arthritis	□ CVA (stroke)	□ Headaches	□ Multiple Sclerosis	□ Shingles
□ Asthma	□ Depression	□ Heart Disease	□ Parkinson's	□ Spina Bifida
□ Cancer	□ Diabetes	□ Hepatitis	□ Pneumonia	□ Vertigo
□ Chicken Pox	□ Ear Infections	□ HIV	□ Scoliosis	□ Other_____
□ Crohn's/Colitis	□ Fibromyalgia	□ High Blood Pressure	□ Seizures	□ Other_____

Surgeries:

□ Appendectomy	□ Coronary Bypass	□ Hernia Repair	□ Laminectomy_____	□ Spinal Fusion
□ C-Section	□ Cosmetic	□ Hip Replacement (Lt / Rt)	□ Pacemaker	Level?_____
□ Carpal Tunnel	□ Gall Bladder	□ Knee Repair (Lt / Rt)	□ Rotator Cuff(Rt /Lt)	□ Other_____

Medications:

Any over the counter meds? □ No □ Yes _____
Any prescription pain meds? □ No □ Yes _____
Any prescription muscle relaxers? □ No □ Yes _____
Any other prescription meds? □ No □ Yes _____

Social and Occupational History:

Recreational activities:_____ Hobbies:_____

Children / ages:_____

Occupation/Job Title: _____
Description of Work: _____

Do you use: Alcohol Y N ____drinks/week Tobacco Y N ____pack/day

Current Condition(s):

Unwanted Condition/Pain (Why are you here today?): _____
Have you ever received Chiropractic Care? Yes No If yes, when? _____

HEALTH EXAMINATION *and* CONSENT FORM

It is required all students complete a history and physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the school administration prior to the first practice.

Name: _____ Sex: M / F Date of birth: _____ Age: _____

Address: _____ Phone: _____

School: _____ Sports: _____ Participation Grade: _____

MEDICAL HISTORY

Fill in details of "YES" answers in space below:	Yes	No
1. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
2. Are you presently taking any medication or pills?	☐	☐
3. Do you have any allergies (medicine, bees, other insects)?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you tire more quickly than your friends during exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you been told you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
5. Do you have any skin problems (itching, rash, acne)?	☐	☐
6. Have you ever had a head injury?	☐	☐
Have you ever been knocked out or unconscious?	☐	☐
Have you ever been diagnosed with a concussion?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger, burned or pinched nerve?	☐	☐
7. Have you ever had heat or muscle cramps?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
8. Do you have trouble breathing or do you cough during or after exercise?	☐	☐
9. Do you use special equipment (pads, braces, neck rolls, mouth guard or eye guards, etc.)?	☐	☐
10. Have you ever had problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
11. Have you had any other medical problems (infectious mononucleosis, diabetes, ect.)?	☐	☐

12. Have you had a medical problem or injury since your last evaluation? ☐ Yes ☐ No

13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of bones or joints?

☐ head ☐ back ☐ shoulder ☐ forearm ☐ hand ☐ hip ☐ knee ☐ ankle

☐ neck ☐ chest ☐ elbow ☐ wrist ☐ finger ☐ thigh ☐ shin ☐ foot

14. Were you born without a kidney, testicle, or any other organ? ☐ Yes ☐ No

15. When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between your periods last year? _____

Explain "YES" answers: _____

CONSENT FORM

(Parent or guardian and student permission and approval)

I herby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

If the health care provider's exam will be performed without compensation as part of the school's health examination program for participation in high school activities, I agree to the waiver provisions as set forth in Idaho Code Section 39-7703 and agree that the health care provider shall be immune from liability as specified in said section.

PARENT OR GUARDIAN SIGNATURE _____ DATE: _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulation of the State Association.

SIGNATURE OF STUDENT _____ DATE: _____

Idaho High School Activities Association

Physical Examination Form

Name: _____ **Date of Birth:** _____

Height _____ **Weight** _____ **BP** _____ / _____ **Pulse** _____ **Vision R 20 /** ____ **L 20 /** ____ **Corrected: Y N**		
	Normal	**Abnormal findings**
Medical		
Pulses		
Heart		
Lungs		
Skin		
Ears, nose, throat		
Pupils		
Abdomen		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE / RECOMMENDATIONS

Clearance:

A. Cleared for all sports and other school-sponsored activates.

B. Cleared after completing evaluation/rehabilitation for:

_____

C. NOT cleared to participate in the following IHSAA sponsored sports /activities:

baseball basketball cheer/dance cross country football golf

soccer softball swimming tennis track volleyball wrestling

NOT cleared for other school-sponsored activities *(example: lacrosse)*:

_____

D. Student is NOT permitted to participate in high school athletics.

Reason: _____

Recommendation:

Name of physician:

Address: _____ Phone: _____

Signature of physician/medical provider: _____ Date: _____

(This *Physical Examination Form* MUST be signed by a licensed physician, physician assistant or nurse practitioner)