Initial History

Patient Name: _____ **Date:** _____

Chief Complaint (What is bothering you?):

_____

_____

_____

What is the Cause or How did it happen?:

_____

_____

_____

When did Condition Begin?: _____

Quality/Character (sharp, dull, ache, numb): _____

Frequency/Duration (When and how long?):_____

_____

What makes it Better/Worse: _____

Referred Pain/Other Symptoms: _____

Previous Occurrences: _____

Secondary Complaints: _____

Previous Medical Care: _____

Previous Chiropractic Care: _____

Do you have any of the following conditions?

❑Heart Attack/Stroke	❑Osteoporosis	❑Artificial Joints	❑Rheumatic Fever
❑Heart surgery / Pacemaker	❑Arthritis	❑Sinus Problems	❑Shingles
❑Artificial Valves	❑Frequent Neck Pain	❑Ulcers / Colitis	❑Cancer / Chemotherapy
❑Heart Murmur	❑Lower Back Problems	❑Emphysema / Glaucoma	❑Alcohol / Drug Abuse
❑Congenital Heart Defect	❑Severe/Frequent Headache	❑High / Low Blood Pressure	❑HIV+ / Aids
❑Kidney Problems	❑Asthma	❑Seizures / Epilepsy /	❑Venereal Disease
❑Diabetes / Tuberculosis	❑Difficulty breathing	❑Psychiatric Problems	❑Hepatitis

Please list any other serious medical condition(s) you have or have had:

_____

Medications you are taking:

❑Nerve Pills ❑Pain Killers(includes aspirin) ❑Muscle relaxers ❑Stimulants ❑Blood thinners ❑Tranquilizers ❑Insulin

❑Others_____

❑Vitamins / Supplements_____

Please list anything you may be allergic to:_____

Please list any *past* serious injuries & dates:_____

_____

Please list any previous surgeries & dates:_____

_____

Initial History

Relevant Family History: _____

Do you smoke? ❑No ❑Yes **How much?** _____ **How long?**_____

Do you wear ❑Heel Lifts ❑Sole Lifts ❑Inner Soles ❑Arch Supports

Women: Are you taking birth control? ❑Yes ❑No **Are you pregnant?** ❑No ❑Yes – **How long?**_____

For Internal Office Use

Vitals: Ht: _____ **Wt:** _____ **BP:** _____ **Pulse:** _____

Other History: _____

Diet: _____

Exercise: _____

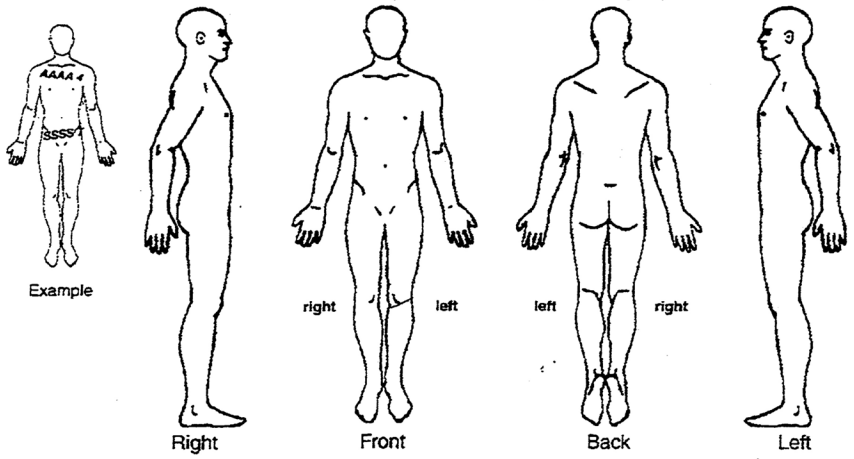
Occupation/Recreation: _____

History Taken By: _____ **Reviewed By Doctor:** _____

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description ➢ Numbness Pins & Needles Burning Aching Stabbing
Symbol ➢ NNNN PPPP BBBB AAAA SSSS

◌ Circle any area of pain not represented by a symbol.



Informed Consent

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly and mutual understanding between the provider and patient.
- I authorize the performance of any necessary diagnostic tests and treatments, which usually include chiropractic manipulation (CMT) for my condition(s). Like most health care procedures, CMT carries with it some risks. Unlike other medical treatments, the serious risks associated with CMT are extremely rare. Included are soreness or initial increased pain symptoms. More rare is dizziness, nausea or flushing, susceptibility of fracture with conditions like osteoporosis. Herniated or bulged discs may worsen even with CMT – it is important to notify the doctor of changes in symptoms. Extremely rare is risk of a certain type of stroke, although this risk is the same with primary medical care and is associated with the nature of neck pain and headache presented by the patient. (Detailed documentation is available upon request).
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the staff. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status or address/contact information.
- I also authorize the provider and or managed care organization to release any information required to process insurance claims.

Signature_____ Date_____