**PATIENT INFORMATION FORM (Please Print)**



**Acknowledgement of Receipt of Notice of Privacy Practices**

|  |  |
| --- | --- |
| **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Patient ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**I hereby acknowledge that I have received a copy of Shaffer Chiropractic Center’s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.**

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| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Patient or Legal Representative** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Printed Name of Patient’s Representative (*if applicable*)** | **Relationship to Patient (*if applicable*)**[ ]  Parent or guardian of unemancipated minor[ ]  Court appointed guardian[ ]  Executor or administrator of decedent's estate[ ]  Power of Attorney |

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 FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ but acknowledgment could not be obtained because:

[ ]  Patient/representative refused to sign

[ ]  Emergency situation prevented us from obtaining acknowledgement at this time

 (will attempt again at a later date)

[ ]  Communication barriers prohibited obtaining acknowledgement (Explain)

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[ ]  Other (Specify)

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INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP FOR CHIROPRACTIC CARE

**CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor’s procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

**ANALYSIS**

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment and mobility allow nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give chiropractic adjustment, or health care, if he is aware that such may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

**RESULTS**

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

**TO THE PATIENT**

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read and understand the foregoing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian Date

**FINANCIAL AGREEMENT AND OFFICE POLICIES**

**Page 1 of 2 (Sign on Page 2)**

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time. These are the most common services we provide:

**PROCEDURE PURPOSE WHEN PERFORMED FEE**

Consultation Discuss your health problems First visit, new injuries, N/C

 and review your case history. or new condition.

Evaluation/ Ascertain the nature and severity of First visit, new conditions, $ 60.00-

Management your health problems. Asses and exacerbations, and progress $110.00.

(Examinations) evaluate your new or current health examinations.

 status and determine an appropriate

 course of action.

Chiropractic Reduce the Vertebral Subluxation As indicated by examination $ 40.00-

Manipulative Complex and help stabilize your or evaluation. $ 75.00.

Treatments spinal or joint problems.

(Adjustments)

Therapy Reduce inflammation and swelling, As indicated by examination $ 5.00-

(Ice Packs) speed the healing process, and help or evaluation. $ 10.00.

 provide relief.

Cervical Contour Help maintain upper body stability As indicated by examination $110.00-

Pillows and increase sleep. or evaluation. $140.00

Arch Support Help maintain lower body stability As indicated by examination $200.00-

Orthotics and strength. or evaluation. $350.00.

Nutritional/ Help balancing nutritional needs. As indicated by examination $ 75.00-

Dietary or evaluation. $ 100.00.

Screenings

**FORMS OF PAYMENT**

Patients are responsible for full payment at the time of service. We accept cash, personal checks, and Visa/MC. Any credit arrangements must be authorized in advance.

***Time of service, self-pay cash discounts are available. Ask the front desk.***

**FINANCIAL AGREEMENT AND OFFICE POLICIES Page 2**





Explain **WHEN** and **HOW** it happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Complaints/Symptoms: \_\_\_ Come and go \_\_\_ Came on gradually \_\_\_ Came on suddenly VAS Score \_\_\_\_\_ / 10

Symptoms have persisted for: \_\_\_ Hours \_\_\_ 1 Day \_\_\_ Days \_\_\_ Weeks \_\_\_Months \_\_\_ Years

Symptoms developed from: \_\_\_ A work-related injury \_\_\_ Auto accident/personal injury \_\_\_ Other

**Describe complaints** (please give details)**:**

Involving Neck & Head: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Involving Mid-back / Shoulders / Arms & Hands: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Involving Low back / Hips / Legs & Feet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities make condition WORSE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities make condition BETTER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had this condition before? \_\_\_ Yes \_\_\_ No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give name of doctors previous seen for this present condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What MEDICATIONS are you presently taking? For what conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Symptoms are **BETTER** in: \_\_ AM \_\_ Midday \_\_ PM Symptoms are **WORSE** in: \_\_ AM \_\_ Midday \_\_ PM \_\_\_ No change with time of day.

**Check symptoms of nervous stress:** Y = Yes N = Leave blank

\_\_\_ Blurring vision \_\_\_ Convulsions \_\_\_ Loss of sleep \_\_\_ Muscle jerking \_\_\_ Confusion

\_\_\_ Paralysis \_\_\_ Fainting \_\_\_ Low resistance \_\_\_ Numbness \_\_\_ Dizziness

\_\_\_ Buzzing/ringing in ears \_\_\_ Depression/crying spells

\_\_\_ Headaches - How often do you have headaches? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of the following?:** Y = Yes N = Leave blank

\_\_\_ Pneumonia \_\_\_ Anemia \_\_\_ Arthritis \_\_\_ Rheumatic fever \_\_\_ Measles \_\_\_ Mumps

\_\_\_ Venereal disease \_\_\_ Diabetes \_\_\_ Lumbago \_\_\_ Appendicitis \_\_\_ Mental disorders \_\_\_ Cancer

\_\_\_ Epilepsy \_\_\_Tuberculosis \_\_\_ Polio \_\_\_ Pleurisy \_\_\_ Nervous disorder \_\_\_ Goiter

\_\_\_ Chicken Pox \_\_\_ Alcoholism \_\_\_ Eczema \_\_\_ Influenza \_\_\_ Whooping cough

**Operations / Spinal procedures:** (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Previous accidents, falls, unconsciousness:** (Please describe fully) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Indicate ability to perform the following activities.**

***Use these codes*:** U = Unable P = Painful D = Difficult L = Limited N = Normal

\_\_\_ Getting in and out of car \_\_\_Bending over forward \_\_\_ Lying on back

\_\_\_ Walking short distances \_\_\_ Coughing or sneezing \_\_\_Sitting at a table

\_\_\_ Lying on side with knees bent \_\_\_ Lying flat on stomach \_\_\_ Turning over in bed

\_\_\_ Bending forward to brush teeth \_\_\_ Standing for more than 1 hour

\_\_\_ Climbing \_\_\_ Kneeling \_\_\_Balancing \_\_\_ Dressing self \_\_\_ Sleeping

\_\_\_ Pushing \_\_\_ Pulling \_\_\_ Reaching \_\_\_ Stooping \_\_\_ Gripping

**Habits:**

Hours of sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee/Tea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all of the appropriate symptoms that you now have or have had recently by frequency. We want all of the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff. Please letter the line beside the symptoms which pertain to you with an **O = OCCASIONAL, F = FREQUENT** or **C = CONSTANT**. If you do not have a symptom ***leave it blank***.

**SUBJECTIVE COMPLAINTS - PAGE 2**

**General Symtoms:**

\_\_\_\_ Headaches

\_\_\_\_ Allergy headaches

\_\_\_\_ Migraine

\_\_\_\_ Tension

\_\_\_\_ Fever

\_\_\_\_ Chills

\_\_\_\_ Fainting

\_\_\_\_ Convulsions

\_\_\_\_ Nervousness

\_\_\_\_ Loss of weight

\_\_\_\_ Obesity

\_\_\_\_ Loss of sleep

\_\_\_\_ Numbness / Pain in arms / hands

\_\_\_\_ Numbness / Pain in legs / feet

\_\_\_\_ Allergy

\_\_\_\_ Wheezing

**E.E.N.T.**:

\_\_\_\_ Failing vision

\_\_\_\_ Near sightedness

\_\_\_\_ Far sightedness

\_\_\_\_ Eye pain

\_\_\_\_ Deafness

\_\_\_\_ Earache

\_\_\_\_ Ear discharge

\_\_\_\_ Nosebleeds

\_\_\_\_ Nasal obstruction

\_\_\_\_ Sore throat

\_\_\_\_ Hoarseness

\_\_\_\_ Hay fever

\_\_\_\_ Asthma

\_\_\_\_ Frequent colds

\_\_\_\_ Enlarged thyroid

\_\_\_\_ Tonsilitis

\_\_\_\_ Sinus infection

\_\_\_\_ Enlarged glands

**Skin:**

\_\_\_\_ Skin eruptions

\_\_\_\_ Psoriasis

\_\_\_\_ Eczema

\_\_\_\_ Itching

\_\_\_\_ Bruise easily

\_\_\_\_ Dryness

\_\_\_\_ Varicose veins

\_\_\_\_ Hives/allergy

**Respiratory:**

\_\_\_\_ Chronic cough

\_\_\_\_ Spitting up phlegm

\_\_\_\_ Spitting up blood

\_\_\_\_ Chest pain

\_\_\_\_ Difficulty breathing

**Cardiovascular:**

\_\_\_\_ Rapid heart beat

\_\_\_\_ Slow heart beat

\_\_\_\_ High blood pressure

\_\_\_\_ Low blood pressure

\_\_\_\_ Pain over heart

\_\_\_\_ Swelling of ankles

\_\_\_\_ Poor circulation

**For Women Only:**

\_\_\_\_ Lumps in breast

\_\_\_\_ Congested breast

\_\_\_\_ Vaginal discharge

\_\_\_\_ Painful menstruation

\_\_\_\_ Pre-menstrual headache

\_\_\_\_ Excessive flow

\_\_\_\_ Irregular cycle

\_\_\_\_ Hot flashes

\_\_\_\_ Menopausal symptoms

\_\_\_\_ Infertility

\_\_\_\_ Previous discharge

\_\_\_\_ **CURRENT** **pregnancy**

Last menstrual cycle was: \_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary Symptoms:**

\_\_\_\_ Frequent urination

\_\_\_\_ Painful urination

\_\_\_\_ Blood in urine

\_\_\_\_ Kidney/bladder infection

\_\_\_\_ Bed wetting

\_\_\_\_ Inability to control bladder

\_\_\_\_ Prostate trouble

\_\_\_\_ Inability to start urination

**Gastrointestinal:**

\_\_\_\_ Poor appetite

\_\_\_\_ Difficult digestion

\_\_\_\_ Excessive hunger

\_\_\_\_ Belching/gas

\_\_\_\_ Nausea

\_\_\_\_ Vomiting

\_\_\_\_ Vomiting of blood

\_\_\_\_ Pain over stomach

\_\_\_\_ Distension of stomach

\_\_\_\_ Constipation

\_\_\_\_ Diarrhea

\_\_\_\_ Colon trouble

\_\_\_\_ Hemorrhoids

\_\_\_\_ Liver trouble

\_\_\_\_ Gall bladder trouble

\_\_\_\_ Jaundice

\_\_\_\_ Colitis

**Muscle / Joint Symptoms:**

\_\_\_\_ Hernia

\_\_\_\_ Arthritis

\_\_\_\_ Swollen Joints

\_\_\_\_ Painful joints

\_\_\_\_ Difficulty walking

\_\_\_\_ Backache / Sciatica

\_\_\_\_ Painful tailbone

\_\_\_\_ Neck pain / stiff neck

\_\_\_\_ Pain between shoulders

\_\_\_\_ Muscle spasms

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

File #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To help us better explain chiropractic and how we may be able to help you, please check the one best answer for each statement below:

1. The primary reason I brush my teeth is to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_ avoid tooth decay and gum disease

\_\_\_ make sure I have healthy teeth and gums

2. When I make decisions I generally \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_ gather the facts and weigh the evidence

\_\_\_ consult my friends and family

\_\_\_ depends on how I feel about it

3. When I get in an automobile, I put on my seatbelt \_\_\_\_\_\_\_\_\_\_.

 \_\_\_ every time \_\_\_ most of the time \_\_\_ some of the time

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

File #: \_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_