



Health History Form

Name: _____ Date: _____ DOB: _____ Age: _____ Gender: Male / Female
 Address: _____ City, State, Zip: _____
 Cell Phone: _____ Home Phone: _____ Email address: _____
 Appointment reminders via text? YES / NO Occupation: _____ Employer's Name: _____
 Who may we thank for referring you? _____ Single/Divorced/Widowed/Married (Spouse's Name: _____)
 # of children, Names, Ages, & Gender _____

Main Health Concern History

| Health Concerns: In order of Severity | Rate of Severity 1=Mild 10=Unbearable | How long have you had this? | Did this start with an injury? | Have you had this before? | Is this constant or comes/goes? |
|---------------------------------------|---|-----------------------------|--------------------------------|---------------------------|---------------------------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

- Please check all that apply when describing the pain? Sharp Soreness Throbbing Tingling Dull Stiffness Spasm Burning Ache Weakness Numbness Shooting
- Does the pain travel anywhere else? Yes No Describe: _____
- How often is this present? Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Intermittent (25% or less)
- Since it started, has the pain gotten better, worse, or stayed the same? _____
- What makes your health concern worse? Nothing Walking Standing Sitting Exercise(moving) Lying down Other
- Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) If so, who?

- Please list all medications, including vitamins/supplements, you are taking and for what?

- Please list any broken bones, surgeries, or hospitalizations you have had and when:



9. Please list any auto accidents or major slips/falls/traumas you have been involved in:

10. Spinal health is especially important during pregnancy; **any chance** that you are pregnant? **YES or NO**

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ___No ___Yes If yes, how many times?

___ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ___No ___Yes If yes, what type of treatment?

Who provided it? _____ How long ago? _____ What were the results ___Favorable

___Unfavorable; Please

explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never** have had:

___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer
___Heart Attack ___Arthritis ___Cerebral Vascular ___Other _____

SOCIAL HISTORY

1. Smoking: ___Cigars ___Pipe ___Cigarettes How often? ___Daily ___Weekends ___Occasionally ___Never

2. Alcoholic Beverages: consumption occurs ___Daily ___Weekends ___Occasionally ___Never

3. Recreational Drug use: ___Daily ___Weekends ___Occasionally ___Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same conditions? ___No ___Yes **If yes, whom:** ___Grandmother
___Grandfather ___Mother ___Father ___Sister(s) ___Brother(s) ___Son(s) ___Daughter(s)

Have they ever been treated for their condition? ___Yes ___No ___I don't know

2. Any other hereditary conditions the doctor should be aware of? ___No ___Yes

QUADRUPLE VISUAL ANALOGUE SCALE

PATIENT NAME: _____

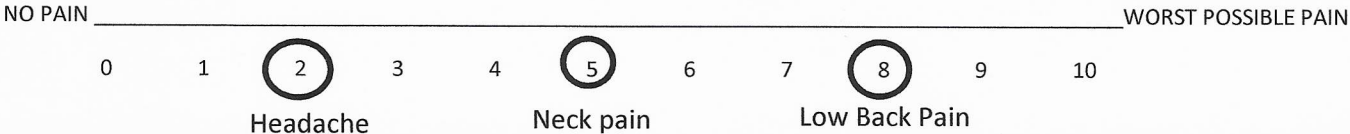
DATE: _____

Please Read Carefully:

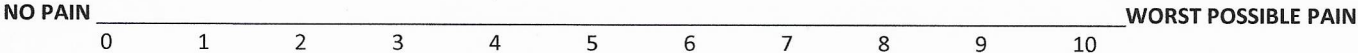
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and label the score for each complaint (see example below). Please indicate your pain level right now, average pain, and pain at its best and worst.

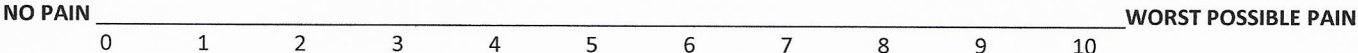
EXAMPLE:



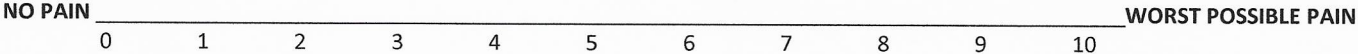
1 – What is your pain RIGHT NOW?



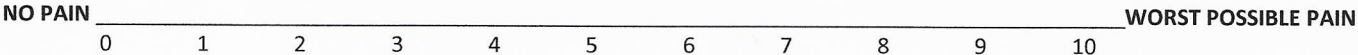
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (how close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner
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INFORMED CONSENT

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE INCLUDE:SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTNACE PER ONE MISSION TO ONE PER TWO MILLION CERBICAL SPINE (NECK) ADJUSTMENTS MAY BE VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OCERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIOPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATION OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTHCARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE. **OUR FOCUS IN THIS OFFICE IS THE VERTEBRAL SUBLUXATION. HOWEVER, IF WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINIDNGS WE WILL ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSES, OR TREATMENT FOR THOSE FINDINGS, WE RECOMMEND THAT YOU SEEK ANOTHER HEALTHCARE PROVIDER. REGARDLESS OF WHAT THE DISEASE IS CALLED, WE DO NOT OFFER TO TREAT IT. NOR DO WE OFFCER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS. OUR ONLY PRACTICE OBJECTIVE IS TO LOCATE, ANAYLZE, AND CORRECT VERTEBRAL SUBLUXATION BY SPECIFIC, NEUROLOGICALLY BASED CHIROPRACTIC ADJUSTMENTS.** CHIROPRACTIC IS A VERY SPECIFIC SCIENCE, AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH CONCERNS AND NEEDS. CHIROPRACTIC IS A SEPARATE AND DISTINCT SCIENCE, ART, AND PRACTICE. **IT IS NOT THE PRACTICE OF MEDICINE.** THE CHIRPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION OR REGIONS OF THE SPINE WITH THE SPECIFIC INTENT OF RE-POSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE. **YOUR COMPLIANCE WITH CARE PLANS, HOME AND SELF-CARE, ETC. IS ESSENTIAL TO MAXIMUM HEALING AND OPTIMAL HEALTH. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTORS ON ANY MATTTER RELATED TO YOUR CARE AT THIS FACILITY.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you agree, they you are bound to abide by such restrictions.

All questions regarding the chiropractor's objectives to my care in this office have been answered to complete satisfaction. I therefore accept care on this basis. I have read and fully understand the above statements.

Printed Name

Signature

Date

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