***Initial History***

Name: ______________________________________________ Date: ________________ SSN: ______-_____-______

Address ______________________________________________City: _________________ State: _____ Zip: ________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Date of Birth: _____/_____/______ Sex: Male / Female Height: __________Weight: __________ Handedness: R / L

Email: __________________________________________Occupation: ________________________________________

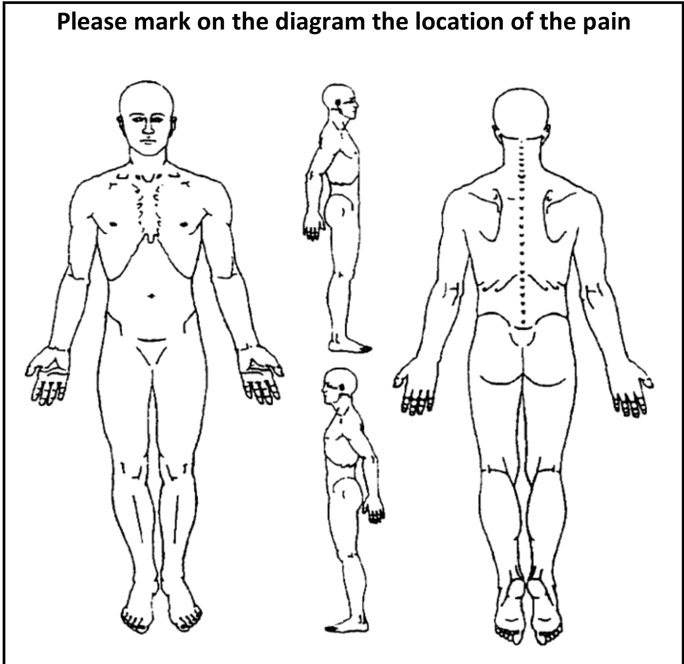
Who referred you to the office? □ Referred by PCP □ Insurance Booklet □ Friend □ Yellow Pages
□ Website/Internet □ Other ___________________________________________

What is bothering you? ______________________________
__________________________________________________
__________________________________________________
__________________________________________________
__________________________________________________

How did it happen? _________________________________
__________________________________________________
__________________________________________________
__________________________________________________
__________________________________________________

When did it start? __________________________________
__________________________________________________

**Please mark on the diagram the location of the pain**



Is this from: □ Auto injury? □ Work injury?

Have you had this pain before? If so, when?______________________________________________________________

*Number & mark the severity of pain you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain):*

(no pain) 0----------1----------2---------3----------4----------5----------6----------7----------8----------9----------10 (severe pain)

*Please describe the type of pain or sensation you are currently experiencing. (Check all that apply)*

□ Aching □ Burning □ Cramps □ Dull □ Numbness □ Sharp □ Shooting □ Stabbing □ Stiffness □ Swelling
□ Throbbing □ Tingling □ Other, describe it:__________________________________________________________

Is the pain constant? □ Yes If not, how often does the pain come and go? ___________________________________
And long does it last each time? __________________________________________________________________

Does it interfere with your □Work □Sleep □Recreation □Daily Routine □Other____________________________

What makes it better? ___________________________________________________________________________

What makes it worse? ____________________________________________________________________________

Have you seen another healthcare practitioner for this pain/condition? □No If yes, who? ___________________________

______________________________________________________________________________

List all Medications/Vitamins: __________________________________________________________

______________________________________________________________________________

List any prior illness or allergies:_______________________________________________________

List any surgeries or broken bones:______________________________________________________

List any hospitalizations:_____________________________________________________________

Are you currently experiencing: □ Fever □ Night Sweats □ Unexplained Weight Gain or Loss □ Change in Appetite □ Dizziness □ Seizures □ Fainting □ Difficulty with speech

Your past medical history. Please Mark all that apply: □ Cancer □ Hypertension □ Heart disease/Stroke □ HIV □ Diabetes □ Kidney disease □ Musculoskeletal disorders

Relevant Family History: ______________________________________________________________

______________________________________________________________________________

Do you have any reason to believe you are pregnant? □ Yes □ No

Remarks (anything else about your condition): ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

***Have you ever been diagnosed with any of the following conditions?***
***(Relative Contraindications)***

❑ **Joint Hypermobility** ❑ **Osteoporosis/Osteopenia** ❑ **Benign Bone Tumors** ❑ **Bleeding Disorders**
❑ **Take Blood Thinners** ❑ **Progressive Radiculopathy**

***NOTE:*** *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***may be contraindicated*** *in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.*

**ONLY If you checked off any of the boxes in this section, please sign here:**___________________________

***Have you ever been diagnosed with any of the following conditions?***
***(Absolute Contraindications)***

❑ **Rheumatoid Arthritis** ❑ **Ankylosing Spondylitis** ❑ **Ligament Laxity** ❑ **Joint Dislocation**
❑ **Recent/Unstable Joints** ❑ **Unstable/Missing Dens at C2** ❑ **Spinal Cancer** ❑ **Spinal/Joint Infection**
❑ **Myelopathy/Cauda Equina Syndrome** ❑ **Vertebrobasilar Insufficiency Syndrome** ❑ **Arterial Aneurysm**

***NOTE:*** *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***is absolutely contraindicated*** *in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.*

**ONLY If you checked off any of the boxes in this section, please sign here:**___________________________

**Chiropractic Informed Consent to Treat**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

## PATIENT ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES PURSUANT TO HIPAA AND CONSENT FOR USE OF HEALTH INFORMATION

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Name_________________________________ Date_______________

By____________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____________________________________
Signature of Parent/Guardian (circle one)