

## PATIENT INFORMATION

PLEASE PRINT

PATIENTS LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ NICKNAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_ TODAYS DATE \_\_\_/\_\_\_/\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ E-MAIL \_\_\_\_\_

SEX M F MARITAL STATUS MARRIED SINGLE WIDOWED DIVORCED DOB \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_\_\_

SPOUSES NAME \_\_\_\_\_ NUMBER OF CHILDREN \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RACE \_\_\_\_\_

REFERRED BY \_\_\_\_\_ PATIENTS OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ NATIVE LANGUAGE \_\_\_\_\_

PHONE NUMBER CELL(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ HOME(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NUMBER CELL(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ HOME(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## HEALTH INFORMATION

***Chiropractors are interested in helping your body function optimally. Frequently, there are events, injuries, or traumas that occur throughout life that affect the development and structure of your spine. Such altered function can influence the nervous system and may affect your general health.***

**Reason(s) for seeking chiropractic care starting with the most severe:**

REASON FOR APPOINTMENT & RELATED HEALTH ISSUES	DATE CONDITION STARTED OR FOR HOW LONG	HAVE YOU HAD THIS BEFORE?	INJURY RELATED?
_____	_____	YES / NO	YES / NO
_____	_____	YES / NO	YES / NO
_____	_____	YES / NO	YES / NO
_____	_____	YES / NO	YES / NO

WHICH OF THESE IS WORST? \_\_\_\_\_

WHAT MAKES IT BETTER? \_\_\_\_\_

WHAT MAKES IT WORSE? \_\_\_\_\_

WHEN DOES IT OCCUR? (ie, morning, evening, with certain activities) \_\_\_\_\_

DOES IT RADIATE OR SHOOT ANYWHERE? \_\_\_\_\_

**Please answer the following to the best of your ability:**

In general, would you say your health is (check one):

- Excellent  Very good  Good  Fair  Poor

Compared to one year ago, how would you rate your general health now?

- Much better now  Somewhat better now  About the same  Somewhat worse now  Much worse now

**As a child:**

Do you know if your birth was a difficult one?  Yes  No  Do not know

Did you have any accidents, falls, traumas, or injuries?  Yes  No

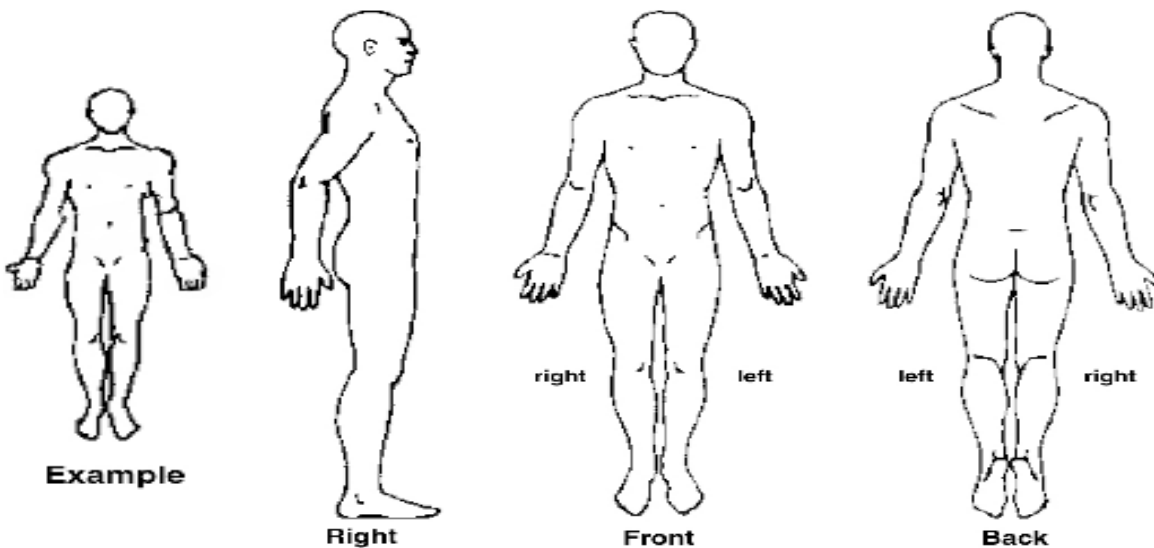
If yes, please explain: \_\_\_\_\_

Did you participate in any sports activities?  Yes  No

If yes, please explain: \_\_\_\_\_

Please mark area(s) of injury or discomfort as shown in the example below.

<b>Description:</b>	<b>Numbness</b>	<b>Pins &amp; Needles</b>	<b>Burning</b>	<b>Aching</b>	<b>Stabbing</b>
<b>Symbol:</b>	NNNN	PPPP	BBBB	AAAA	SSSS



Mark all areas with appropriate symbols and indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

How I feel Today ( 1 being the worst and 10 being the best)

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10 \_\_\_\_\_

**PLEASE CHECK OFF THE FOLLOWING CONDITIONS YOU MAY HAVE HAD IN THE PAST OR HAVE CURRENTLY**

CURRENT	PAST	
_____	_____	HEADACHES
_____	_____	MIGRANES
_____	_____	NECK PAIN
_____	_____	SHOULDER PAIN L R
_____	_____	ARM/HAND PAIN L R
_____	_____	MID BACK PAIN
_____	_____	LOW BACK PAIN
_____	_____	HIP PAIN L R
_____	_____	LEG/FOOT PAIN L R
_____	_____	ARTHRITIS
_____	_____	JOINT PAIN
_____	_____	JOINT SWELLING
_____	_____	FRACTURED BONES
_____	_____	ACCIDENT/FALL
_____	_____	PREGNANT
_____	_____	HIGH BLOOD PRESSURE
_____	_____	LOW BLOOD PRESSURE
_____	_____	EATING DISORDERS
_____	_____	COLD HANDS OR FEET
_____	_____	PANIC ATTACKS
_____	_____	FIBROMIALGA

CURRENT	PAST	
_____	_____	NUMBNESS
_____	_____	SCOLIOSIS
_____	_____	WEAKNESS/FATIGUE
_____	_____	DIZZINESS
_____	_____	CONVULSIONS/EPILEPSY
_____	_____	NAUSEA
_____	_____	NERVOUSNESS
_____	_____	INSOMNIA
_____	_____	IRRITABLE
_____	_____	FREQUENT COLDS/FLU
_____	_____	HIGH STRESS
_____	_____	MOOD CHANGES
_____	_____	VISION CHANGES
_____	_____	SKIN PROBLEMS
_____	_____	ANEMIA
_____	_____	ALLERGIES
_____	_____	PROSTATE PROBLEMS
_____	_____	LIVER/GALLBLADDER
_____	_____	DIGESTIVE ISSUES
_____	_____	MENSTRAL PROBLEMS
_____	_____	IMPOTENCE

CURRENT	PAST	
_____	_____	LEARNING DISABILITIES
_____	_____	ADD/ADHD
_____	_____	CONCENTRATION LOSS
_____	_____	HEARING LOSS
_____	_____	RINGING IN EARS
_____	_____	EAR ACHES/INFECTIONS
_____	_____	NOSE BLEEDS
_____	_____	STROKE
_____	_____	JAW PAIN/CLICKING
_____	_____	BLURRY/DOUBLE VISION
_____	_____	CHEST PAIN L R
_____	_____	HEART PROBLEMS
_____	_____	COUGH
_____	_____	PAIN W COUGH/SNEEZE
_____	_____	CANCER
_____	_____	DIABETES
_____	_____	DEPRESSION
_____	_____	HIV/AIDS
_____	_____	KIDNEY PROBLEMS

ANY OTHER HEALTH ISSUES NOT MENTIONED ABOVE \_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ALL SURGERIES AND DATES \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU HAVE TAKEN OR CURRENTLY TAKE & WHAT CONDITION YOU ARE TAKING THEM FOR \_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER BEEN TO A CHIROPRACTOR? \_\_\_ NO \_\_\_ YES DOCTORS NAME \_\_\_\_\_  
WHAT WAS THE REASON FOR YOUR VISIT? \_\_\_\_\_  
WERE YOU GIVEN HOME CARE TO HELP WITH YOUR CONDITION? \_\_\_ NO \_\_\_ YES  
DID YOU FOLLOW THE DOCTORS RECCOMENDATIONS? \_\_\_ NO \_\_\_ YES  
WHAT IS YOUR MEDICAL DOCTORS NAME? \_\_\_\_\_ PHONE # \_\_\_\_\_

***Health is affected by your nervous system, but is also affected by your environment, the foods you eat, and your lifestyle activities and habits.***

**Health/Risk Factors: Comments:**

Do you smoke?  Yes  No Amount? \_\_\_\_\_ Is your job stressful?  Yes  No  
Do you drink alcohol?  Yes  No Amount? \_\_\_\_\_ Do you sleep well?  Yes  No  
Do you have a healthy diet?  Yes  No Describe it \_\_\_\_\_  
Do you exercise regularly?  Yes  No Times per week \_\_\_\_\_ Cardio or Weights?  
Do you have any silver amalgam fillings?  Yes  No How many? \_\_\_\_\_ How long have you had them? \_\_\_\_\_  
Have you been vaccinated?  Yes  No Do you have any red ink tattoos?  Yes  No  
Have you ever noticed any drastic decline changes in your health?  Yes  No When? \_\_\_\_\_  
Was the issue ever diagnosed?  Yes  No \_\_\_\_\_  
Have you been restored to good health, not just put on medications?  Yes  No  
Can you think of any other habit or activity that has a positive or negative effect on your health?  Yes  No

**What are your health goals?** \_\_\_\_\_  
\_\_\_\_\_

**How do you expect to achieve these goals?** \_\_\_\_\_  
\_\_\_\_\_

## Terms of Acceptance

When we accept a patient for chiropractic care, we must both be working towards the same health care goals. The goal of chiropractic is to detect & eliminate nerve interference in the body. In order to prevent confusion or disappointment, it is important that each patient understand both the goals for health & how we achieve them.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. We utilize specific adjustments of the spine in order to obtain correction of your subluxations.

**Health:** A state of optimal physical, mental, & social well-being and not merely the absence of disease and infirmity. When your body is functioning and healing at 100%.

**Subluxation:** A misalignment of one or more of the vertebrae in the spine which causes decreased nerve function and interference to the transmission of mental impulses. This results in a lowered state of health.

We do not diagnose or treat any disease or condition other than vertebral subluxation. If during the course of a chiropractic spine and nervous system examination we encounter non-chiropractic or unusual findings, we will alert you to those findings. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. We do not offer advice regarding treatment prescribed by other health professionals. **OUR SOLE OBJECTIVE** in this office is to eliminate any interference in the expression of the body's innate healing power.

## Consent for Chiropractic Care

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal adjustments, the goal of chiropractic is primarily to reduce/correct spinal subluxations.

- The chiropractic assessment and chiropractic care provided in this clinic may occur in an open environment.
- I understand that my records and/or x-rays are the property of Exodus Health Center and if at anytime I request a copy of my records and/or x-rays there will be an additional charge for copying them.
- I authorize Exodus Health Center & its agents to administer care as needed, as indicated from exam findings.
- I authorize Exodus Health Center to release information to my doctor and/or insurance company.
- A parent or an approved individual **MUST** accompany their minor child on every visit to the clinic.
- I acknowledge that I have read Exodus Health Center's Notice of Privacy Practices (or had the opportunity to read it if I so chose). I have received a summary of Exodus Health Center's Notice of Privacy Practices and acknowledge that I may have a personal copy of the entire Notice upon request.
- I consent to the use and or disclosure of my protected health information as specified in Exodus Health Center's Notice of Privacy Practices.

I have read and understand the above:

X \_\_\_\_\_  
Patient Signature (custodial parent or legal guardian if patient is a minor)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date