Healthful Chiropractic

Healthful Chiropractic
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CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YY) ____________

Have you consulted a chiropractor before? ◯ No ◯ Yes When? ____________

Patient Number (office use only) ____________

Whom may we thank for referring you? ____________

If so, whom? ____________

Your Last Name ____________ Birth Date (MM/DD/YY) ____________ Age ____________

Your First Name ____________ Your Middle Name (or Initial) ____________

Gender ◯ Male ◯ Female

Address ____________

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

City ____________ State ____________ Zip/Postal Code ____________

Home Phone ____________ Cell Phone ____________

Email Address ____________

Spouse's Name ____________

Emergency Contact ____________ Emergency Contact's Phone ____________

Child's Name & Age ____________

Your Occupation ____________ Work Phone ____________

Child's Name & Age ____________

Primary Care Provider's Name ____________

Preferred Method of Contact ◯ Home Phone ◯ Cell ◯ Work Phone ◯ Email

CONFIDENTIAL HEALTH INFORMATION

Who We Are and What We Do

We are health professionals who are passionate about improving lives. We are on the leading edge of natural healing through a method called upper cervical chiropractic care. This approach helps to regain health and promote wellness in a way many have not experienced.

An upper cervical chiropractor evaluates the tone of the nervous system that governs the healing in the body. An adjustment is much more than simply repositioning the vertebrae in the spine. It is an adjustment to the restrictions that bind the person's health, freeing the life sustaining transmission of mental impulse from the brain to every cell for proper function.

As you entrust us with your care, we will do all we can to **promote** your health, help you to **enhance** the quality of life and be there to **prevent** the deterioration of chronic conditions. We want to **encourage** you to make educated decisions about your health. Our mission is to **allow** the body to **restore** the normal function of every nerve, organ and system. **Healing** from within – as you were designed.

-Healthful Chiropractic

1. The symptom(s) that have prompted me to seek care today include: ____________

2. And are the result of (darken circle): ◯ An accident or injury

◯ Work ◯ Auto ◯ Other ____________

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness ◯ Other ____________

3. Onset When did you first notice your current symptoms? ____________

4. Intensity How extreme are your current symptoms?

0 ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ 10
Absent Uncomfortable Agonizing

5. Duration and Timing When did it start and how often do you feel it?

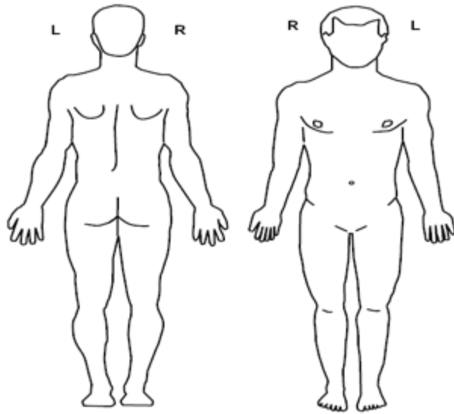
◯ Constant ◯ Comes and goes

How often? ____________

6. Quality of symptoms What does it feel like?

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other ____________

7. Location Where does it hurt? Circle the area(s) on the illustration.



8. Radiation Does it affect other areas of your body? Where? ____________

9. Aggravating or relieving factors What makes it better or worse?

Better ____________

Worst ____________

10. Prior interventions Symptom relief

◯ Prescription meds ◯ Surgery
◯ Over-the-counter ◯ Acupuncture
◯ Homeopathic ◯ Chiropractic
◯ Physical therapy ◯ Massage

11. What else should Dr. Alder know about your current condition? ____________

12. How does your current condition interfere with your:

Work or career: ____________

Recreational Activities: ____________

Household responsibilities: ____________

Personal relationships: ____________

13. Review of Systems

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck Pain	◯	◯	Back Problem	◯	◯	Hip Disorders	◯
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder pain	◯	◯	Elbow/wrist pain	◯	◯	TMJ problems	◯	◯	Poor Posture	

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headaches	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	◯

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive brusing	◯

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	◯

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	Anorexia/ bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	◯

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	Blurred vision	◯	◯	Ringing ears	◯	◯	Hearing loss	◯	◯	Chronic ear infections	◯	◯	Loss of smell	◯	◯	Loss of taste	◯

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	◯

Patient Name ____________

Patient Number ____________

Consultation Notes

Doctor's Initial ____________

(continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	○

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	○

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain / loss	○	○	Weakness	○

Past Personal History

Please identify your past health history, including accidents, injuries, illnesses and treatments.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the pastor **Have** now

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer

Other

Other

15. Operations

Surgical interventions, which may or may not have invluded hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Nutritional supplements
○	○	Medications (list)

17. Injuries

Have you ever…

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Had a sport injury
- ○ Other traumatic injury

18. Family History

Some health issues are hereditary.

FAMILY

Relative	Age (if living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death
Mother		○	○			
Father		○	○			
Sister 1		○	○			
Sister 2		○	○			
Brother 1		○	○			
Brother 2		○	○			
		○	○			

19. Are there any other hereditary health issues that you know about? ____

20. Social History

Tell Dr. Alder about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?
Coffee use	○ Daily	○ Weekly	How much?
Tobacco use	○ Daily	○ Weekly	How much?
Exercising	○ Daily	○ Weekly	How much?
Pain relievers	○ Daily	○ Weekly	How much?
Soft drinks	○ Daily	○ Weekly	How much?
Water intake	○ Daily	○ Weekly	How much?
Hobbies:			

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Patient Name

Patient Number

Consultation Notes

Doctor's Initial

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising our of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Grocery Shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? ___________________

23. How much sleep do you average per night? _______

24. What is your preferred sleeping position? _______________

25. Do you wake well rested in the morning? _________

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ________________________________

28. In addition to the main reason for your visit today, what additional health goals do you have? _______________________

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

Initials ________ **I instruct the chiropractor to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ________ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YY):** ____________

Initials ________ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ________ **I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any services I receive.**

Initials ________ **To the best of my ability , the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's name: ________________________________

Patient Signature ________________________________ Date ________________

Patient Name ________________

Patient Number ________________

Consultation Notes

Doctor's Initial ________________