Confidential Health History

Date_____

Name: _____ Sex: ☐ Female ☐ Male

Address:

_____

Street City State Zip Code

Home Phone #: _____ Work/Cell #: _____

Date of Birth: _____ Age: _____

Occupation: _____ Employer: _____

Marital: ☐ S ☐ M ☐ D ☐W Spouse's Name: _____

Spouse's Occupation: _____

Name's of Children & Ages: _____

_____

Contact Person:_____ Phone #: _____

Have you ever received chiropractic care? ☐ Yes ☐ No

If so, where and when? _____

Referred by: _____

About your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimum health potential. Please take a moment now to fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation for the layers of damage that may exist in your body which are blocking your bodies innate ability to be well and healthy.

(OVER)

Events and Habits

NEONATAL TO ADULT: Many problems have roots in early spinal and/or neurological damage.

YES	NO		Patient comments
		1. PREGNANCY: Did your mother…	
☐	☐	Experience any falls or injuries during pregnancy?	_____
☐	☐	Exercise throughout the pregnancy?	_____
☐	☐	Maintain a proper diet?	_____
☐	☐	Experience any prolonged illness or sickness	_____
		2. BIRTH PROCESS	
☐	☐	Was it a vaginal birth?	_____
☐	☐	Was the delivery long?	_____
☐	☐	Was the delivery difficult?	_____
☐	☐	Were forceps used?	_____
		3. GROWING YEARS: Did you…	
☐	☐	Were you breast fed?	_____
☐	☐	Were you taught how to care for your spine?	_____
☐	☐	Have any notable falls?	_____
☐	☐	Have any significant childhood injuries or illness?	_____
☐	☐	Any childhood surgeries or prolonged medication?	_____
☐	☐	Mental or physical abuse?	_____
		4. ADULTHOOD: Were / Did / Do you…	
☐	☐	Ever in a motor vehicle accident?	_____
☐	☐	Have any other notable falls or injuries?	_____
☐	☐	Hobby / Sport injuries?	_____
☐	☐	Taught proper body movement and lifting?	_____
☐	☐	Smoke?	_____
☐	☐	Drink alcohol?	
		☐ Daily ☐Weekends ☐ Sporadically	_____
☐	☐	Exercise?	
		☐ Daily ☐Weekends ☐ Sporadically	_____
☐	☐	Proper posture?	_____
☐	☐	Eat as healthy as you think you should?	_____
☐	☐	Are you or have you been overweight?	_____
☐	☐	Occupational stress?	_____
☐	☐	Physical stress?	_____
☐	☐	Mental stress?	_____
☐	☐	Other traumas or problems?	_____
		Sleep posture ☐side ☐back ☐stomach	_____
		Sleep surface ☐mattress ☐waterbed	
		Approximate age of bed: _____	_____

Other important information the Doctor should know about:

_____

_____

Symptoms and ill health

As the years go by and the layers of damage increase it is common to experience symptoms and random bouts of ill health as we are brought to our present state of health, which may be less then optimal.

PRESENT REASON FOR CONSULTING OUR OFFICE:

☐ Correction and prevention of existing problem?
☐ Maximizing personal or family health potential?

If you have a specific chief complaint, please describe (briefly).

_____

_____

How and when did this problem start?

_____

_____

Does the pain radiate or travel anywhere else?

_____

_____

Is the problem … ☐ Constant ☐ Intermittent ☐ Worse with movement

Is the condition worse… ☐ In the A.M. ☐ In the P.M. ☐ No change

Is the condition interfering with… ☐ Sleep ☐ Work ☐ Routine ☐ Other

Is the condition getting progressively worse? ☐ Yes ☐ No

Pain is… ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting ☐ Nagging ☐ Other _____

What aggravates your condition / pain? _____

What relieves your condition / pain? _____

Have you had this problem before? ☐ Yes ☐ No

If condition was treated in the past, please describe treatment and results.

_____

_____

Have or were x-rays taken of this area? ☐ Yes ☐ No

When and where? _____

(OVER)

Secondary complaints?

_____

_____

Have you ever or do you presently suffer from any of the following symptoms?
Please list treatment and include any medications being taken.

☐ Headaches _____	☐ Ears ring _____	☐ Stiff/painful neck _____	☐ Nervousness _____
☐ Depression _____	☐ Tension _____	☐ Fatigue _____	☐ Sleep Problems _____
☐ Chest pains _____	☐ Heart/Lung trouble _____	☐ Digestive disorders _____	☐ Cold feet/hands _____
☐ Numbness or pins & needles in legs _____	☐ Numbness or pins & needles in arms _____	☐ Menstrual Problems _____	☐ Arthritis - Where? _____

Are there other medications or treatments you are receiving? (include birth control pills)

_____

_____

List any surgeries and include when?

_____

_____

What, if any side effects have you experienced from your medication or surgery?

_____

_____

Is there a family history of:

	Heart disease	Stroke	Cancer	Arthritis	Diabetes	Other _____
Father's side	☐	☐	☐	☐	☐	☐
Mother's side	☐	☐	☐	☐	☐	☐

About your Care

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Insurance Information

	YES	NO
Is your condition due to an automobile accident?	☐	☐
Date of accident _____		
Have you filed an accident report?	☐	☐
Is your condition due to a job injury?	☐	☐
Date of injury _____		
Have you filed an injury report?	☐	☐
Do you have healthcare insurance that covers chiropractic care?	☐	☐
Company _____		
Policy # _____		
Are you covered by Medicare?	☐	☐
Medicare # _____		
Do you have a supplemental?	☐	☐
Company _____		
Policy # _____		

Please provide your insurance card and information to the front desk.

No insurance? No Problem! Ask about our *Preferred Chiropractic Doctor* (PCD) cash plan that makes chiropractic care affordable for individuals and families.

Payment Information

I understand that as a courtesy to me this office will bill my insurance at my request. I understand that this does not in anyway guarantee payment from my insurance company.

I understand that payment is expected in full for today's visit regardless of insurance status (including charges for history, consult, spinal scan, exam, and x-rays, etc.). Payment is due as services are rendered for future care unless other arrangements have been made.

I will be paying today by: ☐Cash ☐Check ☐Credit Card

_____ _____

Patient Signature (guardian if under 16) Date

We appreciate the opportunity to serve you!

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

If the doctor determines that chiropractic care is appropriate for me and accepts me as a patient, then I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ (Minor or Dependant) by the licensed doctors of chiropractic engaged in practice at Riverside Chiropractic & Vitality Center.

I understand that there is no guarantee as to the results I may experience.

I understand that although chiropractic is extremely safe there are some unlikely risks such as strokes or fractures. I promise to disclose all pertinent information to the doctor to help her make the best judgments in my best interest, based on the facts known.

I agree to follow through on the doctor's recommendations to the best of my ability to optimize the results of my chiropractic care and I will ask whatever questions I have in a timely fashion.

_____
Date

_____
Patient's Name (Print)

_____
Patient's Signature

_____
Relationship/authority if not signed by the patient