The Healing Room
CHIROPRACTIC, LLC

CONFIDENTIAL PATIENT INFORMATION

Date_____/______/_________ Social Security Number ___________________________

Date of Birth_____/______/_________ Age_____ Height_______________ Weight_____________

Last Name______________________ First Name________________________ MI_________

Street Address____ Apt #________________

City__________________________ ST________ ZIP______________ Gender ☐ Male ☐ Female

Home Phone_________________________ Work/Cell Phone________________________

Email Address___________________________ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation_______________________ Spouse's Name________________________ Number of Children & Ages____

Employer's Name & Address____

List your major health complaints & areas of pain____

____

Please check all of the following symptoms and signs that you have or have had in the last 6 months.

GENERAL SYMPTOMS

________ Fever
________ Chills
________ Night Sweats
________ Fainting
________ Loss of Sleep
________ Fatigue
________ Nervousness
________ Loss of Weight
________ Numbness or Pain in arms legs or hands
________ Allergies
________ Headache
________ Dizziness
________ Tremors
________ Convulsions
________ Skin Eruptions/Problems
________ Painful Periods
Other ____________________________

DIGESTIVE PROBLEMS

____________ Nausea/Stomach Upset
____________ Heartburn
____________ Constipation
____________ Diarrhea
____________ Vomiting
____________ Pain Over Stomach
____________ Difficulty Swallowing

CARDIO-VASCULAR

____________ Rapid Heart
____________ Slow Heart
____________ High Blood Pressure
____________ Low Blood Pressure
____________ Pain Over Heart
____________ Previous Heart Trouble
____________ Stroke

EYE, EAR, NOSE & THROAT

_______ Frequent Colds
_______ Sinus Problems
_______ Difficulty Breathing
_______ Wheezing
_______ Asthma
_______ Pain in Eyes
_______ Earache
_______ Ear Noises
_______ Nose Bleeds
_______ Sore Throat
_______ Chronic Cough

MUSCLE & JOINTS

_______ Stiff Neck
_______ Backache
_______ Swollen Joints
_______ Painful Tail Bone
_______ Pain Between Shoulders

HAVE YOU **EVER** HAD ANY OF THE FOLLOWING DISEASES?

_______ Polio
_______ Anemia
_______ Sciatica
_______ Rheumatism
_______ Diabetes
______ Lumbago
______ Eczema
______ Mumps
______ Pneumonia
______ Mental Disorders
______ Appendicitis
______ Alcoholism
______ Epilepsy
______ Goiter
______ Typhoid
______ Heart Disease
______ Malaria
______ Chickenpox
______ Pleurisy
_____ Flu
_____ Measles
_____ Cancer
_____ Arthritis
Other ________________________

HAVE YOU **EVER** HAD ANY OF THE FOLLOWING OPERATIONS?

_________ Appendectomy
_________ Back Surgery
_________ Female Organs
_________ Gall Bladder
__________ Heart Surgery
__________ Hernia Repair
__________ Lung Surgery
__________ Rectal Surgery
_________ Stomach Surgery
_________ Thyroid Operation
_________ Tonsillectomy
Other ______________________________

Recreational Activities____

Describe your own birth (Type – vaginal, Cesarean; Complications before/after birth)_______________________

____

Describe your: Vision________________ Hearing____________________ Coordination______________

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee/Tea ☐ Soft Drinks ☐ Milk

Level of stress in your life: ☐ Mild ☐ Moderate ☐ Extreme Source of stress:____________________________

Do you have injuries from an on-the-job accident? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

Are you now or have you ever been disabled? ☐ Yes ☐ No Accident Date(s)_____/_____/_________

Major Falls or Accidents (Childhood & Adult)____

____

Have you ever had a lapse of memory?____

List any broken bones with dates____

Have you ever had x-rays or an MRI taken? ☐ Yes ☐ No When?_____/_____/_________

Where?______________________________ Why?____________________________________

Do you suffer from any condition other than what which you are consulting us for?___________________________

____

Referred by____________________ Past Chiropractic Care? ☐ Yes ☐ No

Chiropractor's Name______________________________ Date of last visit___/____/______

Who is your family medical doctor?____

When did you last see him/her?_____/_____/_________ Why?____________________________________

What treatment was given (drugs, surgery, therapy, etc.)?____

Have you consulted a specialist? ☐ Yes ☐ No

Who?_____________________________________

Why?____________________ What treatment did you receive?___________________

What supplements are you currently using?____

I understand and agree that all x-rays used for analysis of patient condition remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand and agree that payment is due at the time of my visit unless prior arrangements have been made. Further it is my responsibility to file claims forms with my insurance company. Payments are due for services rendered regardless of insurance company and Medicare's willingness to pay. In the event my insurance company requires more information, I authorize this office to release any and all information.

Patient Signature____ Date_____/_____/_________

Spouse or Guardian Signature____________________________________ Date_____/_____/_________

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. 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. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY PRACTICE OBJECTIVE*** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________ have read and fully understand the above statements.
(Print your name)

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____ ___ / ___ / ___
(Signature)

Consent to evaluate and adjust a minor child

I, ___________________________ being the parent or legal guardian of ______________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation if necessary. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period __/__/__

____ ___ /___ / ___
(Signature)