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

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

_____	Appendectomy	_____	Heart Surgery	_____	Stomach Surgery
_____	Back Surgery	_____	Hernia Repair	_____	Thyroid Operation
_____	Female Organs	_____	Lung Surgery	_____	Tonsillectomy
_____	Gall Bladder	_____	Rectal Surgery	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)