LIFE FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Mobile: _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Married / Single / Other

Date of Birth: _____ Age: _____

Best way to reach you: cell / work / email Occupation: _____ Employer: _____

Who may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION

Full Name: _____

Home: _____ **Mobile:** _____

Relationship: Child / Parent / Spouse / Other: _____

DC / PCP INFORMATION

Previous Chiropractor: _____

Date of Last Adjustment: _____

Primary Care Doctor: _____

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) & Allergies

_____

_____

_____

_____

_____

CURRENT CONDITION INFORMATION — PLEASE ANSWER ALL QUESTIONS

Describe Major Complaint for seeking care today: _____

Onset of Symptoms: _____ Describe how it began:_____

_____

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: _____

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*_____

How does this condition affect your daily activities? *(Describe)* _____

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: _____ Where? _____

Surgery? *(Describe)*_____

Medications? OTC / Prescriptions *(Describe)*_____

Diagnostic testing? X-rays / MRI / CT / Other:_____When and Where? _____

❑ Acupuncture ❑ Massage ❑ Other: _____

Describe any Secondary Complaints: _____

HEALTH HISTORY (PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)

PAST HEALTH HISTORY:(*List, even if it was 20 yrs ago…*)

Surgeries - Date, Type, Reason: _____

_____

_____

_____

Major Injuries/Traumas: (*List, even it it was 20 yrs ago…*)

_____

_____

_____

Major Hospitalizations including year: _____

_____

_____

_____

Vitamins & Supplements: (*List all and frequency*)_____

_____

_____

SOCIAL HISTORY:

Lifestyle:(*Your Hobbies, Exercise, Diet, & Health Goals)*

_____

_____

_____

_____

Habits:

Cigarettes - (#/day) _____

Alcohol - (Amount/day) _____

Coffee/Tea - (Cups/day) _____

HEALTH GOALS

Your initial health goals for care:

1. _____

_____

2. _____

_____

3. _____

_____

How would you rate where you are right now?

Terrible 1 2 3 4 5 Great

Terrible 1 2 3 4 5 Great

Terrible 1 2 3 4 5 Great

Are you *currently* experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _____
- ❑ Leg Problems _____
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: _____

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
  When? _____
- ❑ Have you ever had an auto accident?
  When? _____
- ❑ Other: _____

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____

Gastrointestinal:
❑ Loss of Appetite
❑ Blood in Stool
❑ Change in Bowel Movements
❑ Painful Bowel Movements
❑ Nausea or Vomiting
❑ Abdominal Pain
❑ Frequent Diarrhea
❑ Constipation
❑ Other: _____

Cardiovascular & Heart:
❑ Chest Pains
❑ Rapid or Heartbeat Changes
❑ Blood Pressure Problems
❑ Swelling of Hands, Ankles or Feet
❑ Heart Problems
❑ Other: _____

Respiratory:
❑ Difficulty Breathing
❑ Persistent Cough
❑ Coughing Blood
❑ Asthma or Wheezing
❑ Lung Problems
❑ Other: _____

Eyes & Vision:
❑ Wear contacts/glasses
❑ Blurred or Double Vision
❑ Glaucoma
❑ Eye Disease or Injury
❑ Other: _____

Ears, Nose & Throat:
❑ Bleeding Gums/Mouth Sores
❑ Bad Breath/Bad Taste
❑ Dental Problems
❑ Swollen Throat or Voice Change
❑ Swollen Glands in Neck
❑ Ringing in Ears
❑ Ear Ache/Drainage
❑ Sinus/Allergy Problems
❑ Nose Bleeds
❑ Hearing Loss
❑ Other: _____

Endocrine, Hematologic & Lymphatic:
❑ Thyroid Problems
❑ Diabetes
❑ Excessive Thirst or Urination
❑ Cold Extremities
❑ Heat or Cold Intolerance
❑ Change in Hat or Glove Size
❑ Dry Skin
❑ Glandular or Hormone Problem
❑ Swollen Glands
❑ Anemia
❑ Easily Bruise or Bleed
❑ Phlebitis
❑ Transfusion
❑ Immune System Disorder
❑ Other: _____

Skin & Breasts:
❑ Rash or Itching
❑ Change in Skin Color
❑ Change in Hair or Nails
❑ Non-Healing Sores
❑ Change in Appearance of a Mole
❑ Breast Pain
❑ Breast Lump
❑ Breast Discharge
❑ Other: _____

Women Only:
Are you pregnant? ❑ Yes ❑ No
Due Date: _____
Last Menstrual Period: _____
❑ Infertility
❑ Painful or Irregular Periods
❑ Vaginal Discharge
❑ Other: _____

Pregnancies with Outcome & Date
_____
_____
_____
_____
_____
_____

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events per one million persons per year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

X-Ray Consent

Patient Consent to X-ray

I authorize the performance of a diagnostic x-ray examination of myself, which Dr. Adcock may consider necessary to evaluate my spinal condition. By signing below, I declare to best of my knowledge that there is no chance I may be pregnant at this time. By signing below, I am acknowledging that I have no know limitations that would be contraindicated for an x-ray examination. By signing below, I am consenting to the taking of x-rays, if there is a determined need.

_____ _____

Patient Signature Date

Consent to X-ray a Minor

I am the parent or legal guardian of _____, who is a minor. I authorize the performance of diagnostic x-rays of this child, which Dr. Adcock may consider necessary to accurately analyze _____ spinal condition.

_____ _____

Parent / Legal Guardian Signature Date