Today's Date: _____

FUNCTIONAL Chiropractic & Laser

PATIENT HEALTH RECORD

Welcome to Functional Chiropractic and Laser! All questions contained in this questionnaire are strictly confidential. Please fill out completely and accurately. Let us know if you have any questions.

ABOUT THE PATIENT

First Name:		Last Name:		Middle Initial :
Date of Birth:	Age:	Gender ☐ M ☐ F	SS#:	
Address				
City:		State:	Zip Code:	
Home Phone:		Email Address:		
Cell Phone:		Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Employer:		Type of Work:		
How many children do you have?		Name:	Age: ☐M ☐F	
Name:	Age: ☐M ☐F	Name:	Age: ☐M ☐F	
Name:	Age: ☐M ☐F	Name:	Age: ☐M ☐F	
Name:	Age: ☐M ☐F	Name:	Age: ☐M ☐F	

ABOUT THE SPOUSE OR PARENTS

First Name:	Last Name:		Middle Initial :
Employer	Type of Work:	Work Phone:	

PAST AND CURRENT HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now OR has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or Frequent headaches	☐ Congenital Heart Defect	☐ HIV/AIDS	☐ Thyroid Problems
☐ Sinus Problems	☐ Heart Surgery/pacemaker	☐ Diabetes	☐ Rheumatic Fever
☐ Dizziness	☐ Heart Murmur	☐ Irregular Bowel	☐ Heart Attack
☐ Loss of Sleep	☐ High/Low Blood Pressure	☐ Shingles	☐ Carpal Tunnel
☐ Pain between the shoulders	☐ Difficulty Breathing	☐ Kidney Problems	☐ Seizures
☐ Frequent Neck Pain	☐ Asthma	☐ Hepatitis	
☐ Arthritis	☐ Cancer	☐ Numbness or pain in arms/legs/	
☐ Lower Back Pain	☐ Alcohol/Drug Abuse	☐ Chemotherapy	
☐ Digestive Problems	☐ Venereal Disease	☐ Anemia	☐ Other:_____

FOR WOMEN:

Are you pregnant? ☐ Yes ☐ No	Are you taking Birth Control? ☐ Yes ☐ No	Painful Periods? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No	Irregular Cycles? ☐ Yes ☐ No	

MEDICATIONS YOU NOW TAKE

☐ Stomach Medication	☐ Blood Pressure	☐ Blood Thinners	☐ Other:_____
☐ Pain Killers	☐ Hormone Therapy	☐ Prozac or Similar	_____
☐ Muscle Relaxers	☐ Stimulants	☐ Insulin	_____

HEALTH HABITS

☐ Do you smoke?	☐ Yes	☐ No	_____Packs/day	Do you wear?: ☐ Heel Lifts	☐ Arch Supports
☐ Do you drink alcohol?	☐ Yes	☐ No	_____drinks/week		
☐ Do you drink coffee/soda?	☐ Yes	☐ No	_____cups/day		
☐ Do you exercise?	☐ No	☐ Mild	☐ Moderate	☐ Daily	

YOUR HEALTH AND STRESS HISTORY

When it comes to your health the body is very interconnected, even when things such as physical, chemical, and emotional stress seem unrelated to each other – they are! Any of these "stressors" may cause *vertebral subluxations*, which can cause nerve interference and therefore can inhibit the body to function properly at its optimal ability. Chiropractic care seeks to find these root causes and reduce nerve system interference.

Please tell us about any stress related to your: *BIRTH*		
Any drugs/medicine/tobacco/alcohol used while you were in the womb?	☐ No	☐ Yes - Explain:
Was your birth chemically induced?	☐ No	☐ Yes - Explain:
Were forceps, vacuum extraction, or C-Section performed during birth?	☐ No	☐ Yes - Explain:
Premature delivery?	☐ No	☐ Yes - Explain:
Vaccinations in first year of life?	☐ No	☐ Yes - Explain:
Falls in the first year of life?	☐ No	☐ Yes - Explain:
Any health related problems in the first year of life?	☐ No	☐ Yes - Explain:

Please tell us about any stress related to your: *CHILDHOOD*		
Any falls or injuries?	☐ No	☐ Yes - Explain:
Allergy or Asthma or Respiratory problems?	☐ No	☐ Yes - Explain:
Ear infections?	☐ No	☐ Yes - Explain:
Hyperactivity?	☐ No	☐ Yes - Explain:
Any other health, stress related or injurious problems?	☐ No	☐ Yes - Explain:

Please tell us about any stress: *UP TO THE PRESENT*		
Auto Injuries?	☐ No	☐ Yes - Explain:
Work Injuries?	☐ No	☐ Yes - Explain:
Sports injuries?	☐ No	☐ Yes - Explain:
Work S tress?	☐ No	☐ Yes - Explain:
Family/Home stress?	☐ No	☐ Yes - Explain:
Prescription drug use?	☐ No	☐ Yes - Explain:
Ever hospitalized or had any surgeries?	☐ No	☐ Yes - Explain:
Any major illnesses?	☐ No	☐ Yes - Explain:
Poor Nutrition?	☐ No	☐ Yes - Explain:
Limited exercise?	☐ No	☐ Yes - Explain:

REASON FOR YOUR VISIT

Is the purpose of this visit related to: ☐ Job ☐ Auto ☐ Fall ☐ Sports ☐ Chronic discomfort ☐ Home injury ☐ Daily life ☐ Other – Please explain:

If job related, have you made a report of your accident to your employer? ☐ No ☐ Yes

When did this health challenge begin?

Has this: ☐ Gotten worse ☐ Stayed same ☐ Comes and goes ☐ Gotten better

Does this interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities – Explain:

Has this condition occurred before? ☐ No ☐ Yes - Explain:

Have you seen any other professional for this? ☐ No ☐ Yes - Explain:
Dr.'s Name(s):
Type of treatment:
Results:

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

Doctors of Chiropractic work with the nervous system?	☐ No	☐ Yes
The nervous system controls all bodily functions and systems?	☐ No	☐ Yes
Chiropractic is the largest natural healing profession in the world?	☐ No	☐ Yes
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐ No	☐ Yes

YOUR EXPERIENCE WITH CHIROPRACTIC CARE

Who referred you to this office?

Have you been adjusted by a chiropractor before? ☐ No ☐ Yes

Reason for those visits?

Previous Chiropractic Doctor's name:

Approximate date of last visit:

Has any adult in your family seen a Chiropractor? ☐ No ☐ Yes

Has any child in your family seen a chiropractor? ☐ No ☐ Yes

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct cause of pain, and others for whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ **Relief Care**: Symptomatic relief of pain or discomfort
- ☐ **Corrective Care:**: Correcting and relieving the **CAUSE** of the problem as well as the symptoms.
- ☐ **Comprehensive Care:** Caring for the WHOLE body, not just the symptomatic area. This works on achieving the highest state of health in your body.
- ☐ **Doctor Recommended Care:**: I want to select the type of care appropriate for my condition and recommend care that will be the best for my health and wellness.

AUTHORIZATION FOR CARE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I hereby authorize the Doctor(s) to work with my condition through the use of adjustments as he/she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I authorize the release of records to assist in collections.

Patient or Guardian Signature:_____ Date: _____