CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license for your personal records. All information you supply is confidential. We comply with all federal privacy standards.

Please print clearly. Thank you.

Thank you for choosing Foundation Chiropractic. We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle. We look forward to helping you achieve your health goals.

Today's Date____/____/____ Have you been under the care of a chiropractor before? YES / NO

If you answered yes, when and who did you see?____

Last Name___________________________________ First Name _____________________

Male____ Female____ Date of birth____/____/____ Age_____ Number of children______

Marital Status: S M D W Spouse/Partner's Name______

Mailing address________________________________

City ____ State ________ Zip______

Home phone (________)_________-_________ Cell phone (_________)_________-_________

Email ______________________________________ May we email/text reminders?______

What made you decide to visit our office today?____________

Who may we thank for referring you?_____________________

Is your present complaint related to workman's compensation injuries or an accident? YES / NO

Employer _________________________________ Occupation________________________

Preferred contact method?______________________________

Primary Care Provider/Family Physician_________________________

Emergency Contact _________________________________ Phone # (______)______-_______

When was your last spinal examination?___________________

Have you ever been told that you have a spinal curvature, arthritis, or other spinal problem?______

____

Please rate your PHYSICAL stress level on a scale of 0-10, 0 being no stress and 10 being the most stress imaginable. 0 1 2 3 4 5 6 7 8 9 10

Please list your PHYSICAL stressors____

Please rate your EMOTIONAL/MENTAL stress level on a scale of 0-10, 0 being no stress and 10 being the most stress imaginable. 0 1 2 3 4 5 6 7 8 9 10

Please list your EMOTIONAL/MENTAL stressors_______________________________

How much sleep do you get per night on average?___________

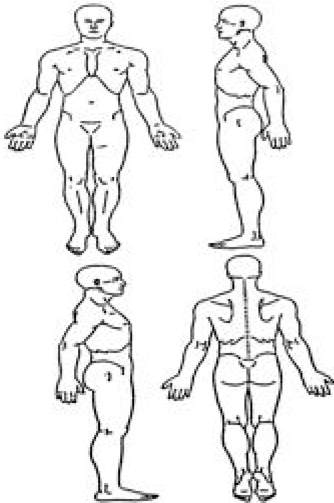
Do you wake up feeling rested or are you still tired upon waking?_______________

What is your current complaint(s)?____

When did your secondary conditions (symptoms) first appear?________________________

Please describe your secondary conditions

____



Please mark with an X on the picture to your left where you are experiencing secondary conditions.

What activities make your secondary conditions worse?

____

What activities make your secondary conditions better?

____

Please rate the intensity of your secondary conditions on a scale of 0-10, 0 being no intensity and 10 being the most intensity imaginable.

0 1 2 3 4 5 6 7 8 9 10

What do your secondary conditions prohibit you from doing that you wish to do? ______________________

____

Are you seeing anyone else for these complaints?

Who?______________________________________

Do you have any allergies (if so, please list)?____

Do you currently use tobacco products (list type, amount and frequency)?__________________________

Do you consume alcohol (list amount and frequency)?____

Do you consume caffeinated beverages such as soda, coffee, tea, etc. (list type, amount and frequency)?__________________________________

Please list current medications, including nutritional supplements.

Medication/Supplement	Dosage	Frequency (i.e. 2x/day)	Start date

How many 8 ounce glasses of water do you drink per day?___________________________________

Please list 3 of your top health goals

1)____

2)____

3)____

Are you currently under the care of any other healthcare provider? Yes / No

If so, who, and for what?____

Please list any major childhood illnesses____

Please list any major illnesses as an adult____

Please list any major injuries/surgeries____

Review of Systems

(Please circle all that apply)

Constitutional	None daytime drowsiness fever night sweats chills fatigue weight gain weight loss loss of appetite
Eyes/Vision	None cataracts itching corrective lenses/glasses blindness double vision sensitive to light blind spots tearing
Ears, Nose & Throat	None fainting runny nose dizziness frequent sore throat loss of sense of smell sinus infection ear discharge headaches nosebleeds ear pain hearing loss nasal congestion
Respiration	None cough shortness of breath wheezing asthma coughing up blood sputum production

Cardiovascular	None high blood pressure varicose veins leg pain low blood pressure difficulty breathing while lying down shortness of breath heart murmur racing heartbeat ulcers
Gastrointestinal	None belching/gas difficulty swallowing jaundice abdominal pain black/tarry stool heartburn ulcers abnormal stool constipation diarrhea indigestion hemorrhoids rectal bleeding loss of bowel/bladder control
Female	None birth control frequent urination vaginal discharge cramps abnormal vaginal bleeding breast lump/pain hormone therapy urine retention/incontinence burning urination irregular periods I am currently pregnant I am NOT currently pregnant Date of the beginning of my last menstrual period ____/____/____ ____# of complicated pregnancies ____# of uncomplicated pregnancies ____# of C-sections ____# of vaginal deliveries ____# of miscarriages ____# of terminated pregnancies
Male	None burning urination frequent urination prostate problems erectile dysfunction hesitancy/dribbling urinary incontinence
Sexual Health	Do you have any concerns about your sexual health? YES NO
Skin	None change in skin color history of skin disorders rash hives change in nail texture hair loss numbness psoriasis
Nervous System	None limb weakness seizures stroke dizziness sleep disturbances loss of consciousness unsteadiness/loss of balance headache facial weakness loss of memory slurred speech numbness
Psychological	None bi-polar disorder depression memory loss anxiety confusion insomnia mood change behavioral change change in appetite

Hematologic	None bleeding blood transfusion fatigue anemia bruises easily lymph node swelling blood clotting

Review the following activities and indicate how your secondary conditions affect each activity.

Sitting	No effect	Mild effect	Moderate effect	Severe effect
Rising out of a chair	No effect	Mild effect	Moderate effect	Severe effect
Standing	No effect	Mild effect	Moderate effect	Severe effect
Walking	No effect	Mild effect	Moderate effect	Severe effect
Lying down	No effect	Mild effect	Moderate effect	Severe effect
Bending over	No effect	Mild effect	Moderate effect	Severe effect
Climbing stairs	No effect	Mild effect	Moderate effect	Severe effect
Using a computer	No effect	Mild effect	Moderate effect	Severe effect
Getting in/out of a car	No effect	Mild effect	Moderate effect	Severe effect
Driving	No effect	Mild effect	Moderate effect	Severe effect
Looking over shoulder	No effect	Mild effect	Moderate effect	Severe effect
Personal care	No effect	Mild effect	Moderate effect	Severe effect
Household chores	No effect	Mild effect	Moderate effect	Severe effect
Lifting a 30 lb box	No effect	Mild effect	Moderate effect	Severe effect
Reaching overhead	No effect	Mild effect	Moderate effect	Severe effect
Dressing yourself	No effect	Mild effect	Moderate effect	Severe effect
Love life	No effect	Mild effect	Moderate effect	Severe effect
Getting to sleep	No effect	Mild effect	Moderate effect	Severe effect
Staying asleep	No effect	Mild effect	Moderate effect	Severe effect
Concentrating	No effect	Mild effect	Moderate effect	Severe effect
Exercising	No effect	Mild effect	Moderate effect	Severe effect
Yard work	No effect	Mild effect	Moderate effect	Severe effect

To set clear expectations, improve communication and help you get the best results possible as quickly as possible, please read each statement below and initial your understanding/agreement.

________ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this clinic is based on the best available evidence and designed to reduce or correct the primary condition (vertebral subluxation). Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

________ I grant permission to be called/texted to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this clinic.

________ I acknowledge that any insurance I have in an agreement between the insurance company and I and that I am responsible for the payment of any covered or non-covered services that I receive.

________ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient signature and date____
If the patient is a minor child, print child's full
name:____

Doctor's initials __________