Van Roo FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH RECORD

(PLEASE PRINT)

FULL LEGAL NAME: ______ DATE OF BIRTH: ______
STREET ADDRESS / P.O. BOX ______ HOME PHONE: ______
CITY / STATE / ZIP: ______ MOBILE PHONE: ______
SOCIAL SECURITY NUMBER: ______ WORK PHONE: ______
YOUR EMPLOYER: ______ JOB TITLE: ______
MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED EMAIL: ______
SPOUSE'S NAME: ______ SPOUSE'S DATE OF BIRTH: ______ SPOUSE'S EMPLOYER: ______
NAMES / AGES OF CHILDREN: ______
WHO SHOULD WE NOTIFY IN AN EMERGENCY? ______ RELATIONSHIP: ______ PHONE #: ______
WHO IS YOUR MEDICAL DOCTOR? ______ FACILITY / CITY: ______
DID ANY OF THE FOLLOWING REFER YOU TO US? ☐MY M.D. ☐ANOTHER PERSON: ______ OTHER: ______

HISTORY OF PRESENT ILLNESS / INJURY

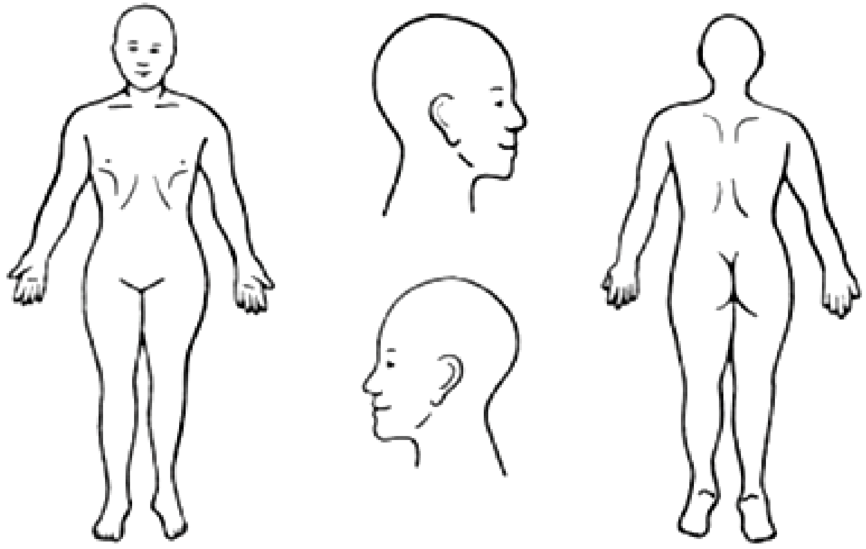
FILL OUT THIS SECTION BY MARKING THE AREA WITH THE DESCRIBED SENSATION USING THE APPROPRIATE SYMBOLS FROM THE LEFT.

X X X BURNING PAIN
((((ACHING PAIN
0 0 0 PINS & NEEDLES
- - - - NUMBNESS
: : : : SHARP PAIN

PLEASE COMPLETE:
____ CONSTANT
____ COME & GO

____ GETTING BETTER
____ GETTING WORSE
____ STAYING SAME

BETTER:		WORSE:
____	AM	____
____	MID-DAY	____
____	PM	____



RATE YOUR DISCOMFORT/SYMPTOM(S):

ENTER THE NUMBER BELOW THAT CORRESPONDS WITH YOUR DEGREE OF DISCOMFORT. **"0"** IS NO PAIN/SYMPTOM(S), **"100"** IS INTOLERABLE PAIN/SYMPTOMS.

NECK (0= NO PAIN):	**MID BACK (0= NO PAIN):**	**LOW BACK (0= NO PAIN):**	______	______
BEST: ____/100	BEST: ____/100	BEST: ____/100	BEST: ____/100	BEST: ____/100
WORST: ____/100	WORST: ____/100	WORST: ____/100	WORST: ____/100	WORST: ____/100
NOW: ____/100	NOW: ____/100	NOW: ____/100	NOW: ____/100	NOW: ____/100
USUAL: ____/100	USUAL: ____/100	USUAL: ____/100	USUAL: ____/100	USUAL: ____/100

HOW DID IT OCCUR? ☐ WORK – RELATED INJURY ☐ AUTO ACCIDENT ☐ OTHER: ______
WHEN DID THEY BEGIN? ______ HAVE YOU MISSED WORK? ☐**YES** ☐**NO** HOW MUCH? ______

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THE FOLLOWING CODES:

U – UNABLE L – LIMITED P – PAINFUL D – DIFFICULT N – NORMAL H – HAVEN'T TRIED

1. ____ LYING ON BACK
2. ____ LYING ON SIDES
3. ____ LYING ON STOMACH
4. ____ TURNING OVER IN BED
5. ____ SEXUAL ACTIVITY
6. ____ GETTING IN / OUT OF CAR
7. ____ PUSHING / PULLING
8. ____ UP/DOWN STAIRS
9. ____ BENDING FORWARD/LIFTING
10. ____ PROLONGED STANDING
11. ____ USING A COMPUTER
12. ____ SITTING/DRIVING/RIDING
13. ____ DRESSING SELF
14. ____ WALKING
15. ____ COUGH / SNEEZE/ GRUNT
16. ______

WHAT MAKES THE CONDITION BETTER?

HEAD / NECK ______ SHOULDER, ARM, HAND ______
MID BACK ______ HIP, LEG, FOOT ______
LOW BACK OTHER

Patient Demographics

(*Required per Federal Guidelines)

***Gender:** ☐Male ☐Female ***Ethnicity:** ☐Hispanic ☐Not Hispanic

***Race (Select One):** ☐Alaska Native ☐American Indian ☐Asian ☐Black/African American ☐Native Hawaiian ☐Other Pacific Islander ☐White/Caucasian ☐Other: ______________________________________

***Preferred Language:** ☐English ☐Hmong ☐Lao ☐Spanish ☐Vietnamese ☐Other: ____________________________

***Drug Allergies:** ☐None **-or-** ☐ List: ____

***Smoking Status (For Individuals Age 13 Years and Older):**

☐Heavy Smoker (1/2-pack per day or more) ☐Light Smoker (Less than 1/2-pack per day)

☐Former Smoker (_____Packs/Day or _____Cigs/Day. Smoked from Age: _____ to Age: _____)

☐Never Smoked

☐Smoking Status Unknown

***Current Prescription Medications** *Name of Prescription (Brand or Generic)*	**Dose** *(mg, mL, etc.*	**Form** *(Tab, Caps, Inj., Etc.)*	**Frequency** *(# Per Day/Week/Mo.)*
______________________	______________	________________	_______ *x Per* ________
______________________	______________	________________	_______ *x Per* ________
______________________	______________	________________	_______ *x Per* ________
______________________	______________	________________	_______ *x Per* ________
______________________	______________	________________	_______ *x Per* ________
______________________	______________	________________	_______ *x Per* ________

If you need more space, please attach additional sheet of paper with **Name of Rx, Dosage, Form, & Frequency of Usage.*

*** How do you prefer to receive follow-up reminders for preventative care? (Select one)**

☐Letter by Mail ☐Phone ☐E-Mail: ____

☐ I wish to view my records at my leisure on the Van Roo Family Chiropractic online Patient Portal. I can also make specific requests for individual notes to be printed and handed or mailed to me at any time. **(Recommended*)**

☐ I wish to be (Mailed / Emailed) a clinical summary after EVERY chiropractic visit at this office, indefinitely.

Would You Like To Receive Text/Email Reminders for Your Appointments? ☐**Yes** ☐**No** **(If "Yes", Please Complete Below)**

☐**Text Message Preferred, List Mobile Carrier (e.g. Verizon): ____________________** ☐**Email Preferred**

Please provide Your:

Height: _________ **Weight:** ___________ lbs.

Doctor will gather:

Temp:_________ Resp:_________ Pulse:__________

Blood Pressure: ________ / ________ (Sit / Stand)

YES	NO	
☐	☐	Does the Discomfort Interfere with your Sleep?
		♦ How Many Times Does It Wake You Up? ____________
☐	☐	Do You Sleep with a Pillow? How Many? ____________
		♦ Where? ____________
		♦ What Positions Do You Sleep In? ____________
		♦ How Old is Your Mattress? ____________
		♦ How Much Sleep Do You Average/Night? ____________
☐	☐	Does Using a Heating Pad Help/Hurt? How? ____________
☐	☐	Does Using an Ice Pack Help/Hurt? How? ____________
☐	☐	Do You Wear a Heel Lift? Which Side? (**Left** or **Right**)
☐	☐	Do You Wear Foot Orthotics?

Females: Are You Pregnant? ☐Yes ☐No

Due Date: ____________ Doctor: ____________

Date of Last Gynecological & Breast Exam: ____________

Males: Date of Last Prostate & Testicular Exam: ____________

Neck & Headache Questions

YES	NO	
☐	☐	Difficulty Turning Head? ☐ Left ☐Right
☐	☐	Do You Hear Grating / Crackling Sounds?
☐	☐	Do You Try to "Crack" Your Own Neck?
☐	☐	Do You Get Pain or Cracking in Jaw?
☐	☐	Do You have Nausea, Vomiting, Visual Disturbances, Altered Hearing, Ringing in Ears, or Loss of Balance?
☐	☐	Do You Get Pain or Pressure Behind the Eye(s)? R or L
☐	☐	Do You Have Abnormal Blood Pressure?

♦ Location of Headaches: ____________

♦ Frequency of Headaches: ____________ per ____________

♦ Date of Last Eye Exam: ____________ . Any Rx Changes? Y or N

Low Back Pain Questions

YES	NO	
☐	☐	Does Pain Radiate to the Abdomen and/or Groin?
☐	☐	Any Impairment of Bowel or Bladder Function?
		♦ Explain? ____________
☐	☐	Do You Try to "Crack" Your Own Back?

Past Medical History

How Many Times Have You Had the Condition That You Are Seeing Us for Today? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Please List Any Other Health Conditions you Have: (Check All That Apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer

☐ Thyroid ☐ Infertility Issues ☐ Others: ____________

Have You Ever Seen a Chiropractor Before? ☐**Yes** ☐**No**

♦ When Was the Last Time You Were Seen? ____________ Which Dr./Facility? ____________

♦ For What Problem(s)? ____________ Were You Helped? ____________

♦ How Often Were You Being Seen? ____________ Why Did You Leave? ____________

List Any Other Chiropractors You've Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

List Any MD's, Physical Therapists, or Other Health Professionals You've Seen for This Condition Before: (Use More Paper as needed.)

Date	Name	Facility	Condition(s)	Treatment Type(s)

Describe Any Other Self Care Remedies You've Attempted to Alleviate Your Condition? (e.g. topical ointments or Home Medical Equipment such as braces/supports, Cervical Pillow, Low Back Support Belt, Stretching, Exercising, etc.) If Yes, What?

____

List Any Vitamins or Supplements You Take for Specific Conditions or For General Wellness:

Name of Vitamin/Supplement	Dosage?	For What Condition(s)	Where Do You Buy It?

Describe Any Major Illnesses, Injuries, Falls, Hospitalizations, Auto Accidents, and/or Surgeries: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

Family Health History

Mother: Alive? ☐Yes ☐No Health Conditions: ____________________

Father: Alive? ☐Yes ☐No Health Conditions: ____________________

Brothers/Sisters: How Many of Each? __________ Health Conditions: ____________________

Children: How Many? __________ Health Conditions: ____________________

Social Health History

Student: ☐N/A ☐Part-Time ☐Full-Time ☐School: ____________________

Occupation: ____________________ Hrs Per Week : __________ Yrs on Job: __________ Yrs with Employer: __________

Recreational Activities / Hobbies: ____________________

Yes	No	
☐	☐	Do You Exercise? How Often? __________ In What Way? __________
		How Much Water Do You Drink? __________
☐	☐	Do You Consume Caffeine? How Much & How Often? __________
☐	☐	Do You Consume Alcohol? How Much & How Often? __________
☐	☐	Do You Have High Stress Levels at Home? If So, Why? __________
☐	☐	Do You Have High Stress Levels at Work/School? If So, Why? __________

Bournemouth Questionnaire

Over the past week, on average, how would you rate your pain? (0–no pain, 10–worst possible pain) ______ /10

Over the past week, how much has your pain interfered with your daily activities (housework, dressing, lifting, driving, etc.)? (0 – no interference, 10 – unable to perform) ______ /10

Over the past week, how much has your pain interfered with your ability to take part in recreational, social, & family activities? (0 – no interference, 10 – unable to perform) ______ /10

Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating or relaxing) have you been feeling? (0 – not at all anxious, 10 – extremely anxious) ______ /10

Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?** (0 – not at all depressed, 10 – extremely depressed) ______ /10

**Are you interested in a referral for outside counseling for depression? ☐Yes ☐No

Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain? (0 – have made it no worse, 10 – have made it much worse) ______ /10

Over the past week, how much have you been able to control (reduce/help) your pain on your own? (0 – completely controlled, 10 – no control whatsoever) ______ /10

Total Points: ______ **/70** **Total:** __________ **%**

Your Quality of Life

What Is/Are the Major Stresses in Your Life Currently: (Check All That Apply)

☐ Your Health ☐ Relationship(s) ☐ Work/School ☐ Your Finances ☐ Other: ____________________

What Would Be the Most Significant Thing(s) You Could Do To Improve Your Health: (Check All That Apply)

☐ Being Here! ☐ Diet/Exercise ☐ Better Sleep ☐ I Don't Know ☐ Other: ____________________

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS NOW OR IN THE PAST? (PLEASE MARK **Y** FOR YES OR **N** FOR NO IN EACH OF THE FOLLOWING:)

1. ____ **EYES** (GLASSES, CONTACTS, CATARACTS, GLAUCOMA, ETC.)
2. ____ **EARS, MOUTH, NOSE, THROAT** (HEARING LOSS, SINUS, ETC.)
3. ____ **CARDIOVASCULAR** (HEART, HIGH B.P., HIGH CHOLESTEROL, STROKE)
4. ____ **RESPIRATORY** (LUNGS, BREATHING, ASTHMA, C.O.P.D., ETC.)
5. ____ **NEUROLOGICAL** (NERVE ISSUES, M.S., WEAKNESS, NUMBNESS, ETC.)
6. ____ **ENDOCRINE** (THYROID, HORMONAL IMBALANCES, LIVER, ETC.)
7. ____**CONSTITUTIONAL** (FEVER, CHILLS, NAUSEA, DIZZINESS, ETC.)
8. ____**HEMATOLOGICAL** (ANEMIA, THIN BLOOD, SICKLE CELL, ETC.)
9. _____ **GASTRO-INTESTINAL** (ACID REFLUX, ULCERS, GALL BLADDER, I.B.S., ETC.)
10. ____ **GENITO-URINARY** (MALE/FEMALE REPRODUCTION, KIDNEYS, BLADDER, ETC.)
11. ____ **MUSCULOSKELETAL** (BREAKS, ARTHRITIS, OSTEOPOROSIS, DISCS, ETC.)
12. ____ **SKIN** (RASHES, SKIN CANCER, DRYNESS, PSORIASIS, ECZEMA, HAIR, ETC.)
13. ____ **PSYCHIATRIC** (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC.)
14. ____ **INTERNAL ORGANS** (DIABETES, APPENDIX, SPLEEN, LIVER, ETC.)
15. ____ **ADDICTIONS** (PAST OR PRESENT: ALCOHOL, DRUGS, MEDS, ETC.)
16. ____ **OTHERS**: ____

PLEASE DESCRIBE IN MORE DETAIL: ____

TREATMENT OPTIONS

☐ I WANT THE DOCTOR TO EXPLAIN MORE

☐ I WANT THE DOCTOR TO CHOOSE FOR ME

WITH WHAT YOU KNOW NOW, HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

☐ PHASE 1: **TEMPORARY PAIN RELIEF:** (HELP CALM THE SYMPTOM(S), BUT DO NOT FIX THE PROBLEM LONG TERM).

- PRO: QUICK, INEXPENSIVE, MASK THE PROBLEM — CON: SYMPTOMS LIKELY TO RETURN OR RELAPSE IN THE FUTURE

☐ PHASE 2: **TOTAL CORRECTION:** (CALM THE SYMPTOM(S) & RESOLVE THE CAUSE OF THE PROBLEM FOR FUTURE STABILITY).

- PRO: LONGER LASTING RESULTS, FIXING THE PROBLEM — CON: CONTINUED CARE AFTER INITIAL SYMPTOMS HAVE CALMED

☐ PHASE 3: **MAXIMUM CORRECTION FOLLOWED BY A REGULAR WELLNESS SCHEDULE**: (*TO BE DETERMINED BY YOUR DOCTOR*)

- PRO: MAINTAIN GAINS & PREVENT FUTURE PROBLEMS — CON: STAYING MOTIVATED, INCREASED TIME & EFFORT COMMITMENT

NOTES:

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PATIENT SIGNATURE: ______________________________ **DATE:** ______________

GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

D.C. SIGNATURE: ______________________________ **DATE:** ______________

Van Roo FAMILY CHIROPRACTIC

INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFORE, IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULLY INFORMED IN CONSENTING TO TREATMENT FROM OUR **VAN ROO FAMILY CHIROPRACTIC** TEAM.

OUR CHIROPRACTIC OFFICE USES TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTIONS, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU, WITH YOUR PERMISSION.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE – THOUGH EXTRAORDINARILY RARE, STROKE IS THE MOST SERIOUS POTENTIAL COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN IT OCCURS, IT MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS, DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHIN THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT BETWEEN 1 PER 400,000 TREATMENTS TO 1 PER 5.8 MILLION TREATMENTS. USING DATA FROM 2 OF THE LARGEST CHIROPRACTIC INSURERS, THE RISK OF SERIOUS ARTERIAL STROKE SYNDROMES IS SHOW TO BE LESS THAN 1 IN 2 MILLION TO 1 IN 3.8-5.8 MILLION CERVICAL MANIPULATIONS. THE MOST COMMON TYPE OF VASCULAR LESION WITH THIS ASSOCIATION IS A DISSECTION OF THE VERTEBRAL ARTERY (VBA). (*CURRENT CONCEPTS: SPINAL MANIPULATION AND CERVICAL ARTERIAL INCIDENTS, 2005.)* **A 2008 STUDY IN SPINE JOURNAL STATES: "WE FOUND NO EVIDENCE OF EXCESS RISK OF VBA STROKE ASSOCIATED WITH CHIROPRACTIC CARE COMPARED TO PRIMARY CARE." THEREFORE THE RISK IS THE SAME NO MATTER WHOM YOU CHOOSE TO SEE.**

SORENESS – CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST-TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IT IS GENERALLY NOT DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY – OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISK INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY – MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS TAKING PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES DEEMED "AT-RISK." TREATMENT IS PERFORMED CAREFULLY AND GENTLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS – HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS – THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE INDEED RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS OUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL BEST ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

PATIENT'S NAME PRINTED ______________________ TODAY'S DATE ______________________

PATIENT'S SIGNATURE ______________________ PARENT OR GUARDIAN'S SIGNATURE FOR MINOR ______________________