

# CONFIDENTIAL PATIENT HEALTH RECORD

(PLEASE PRINT)

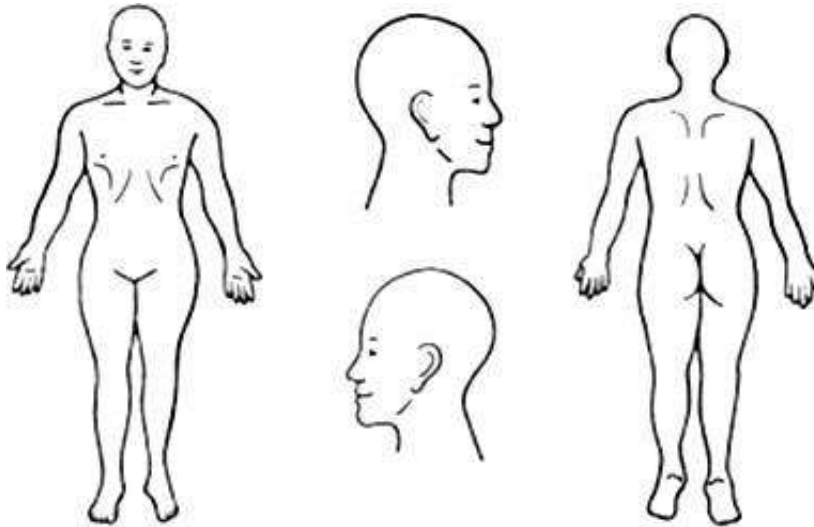
FULL LEGAL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 STREET ADDRESS / P.O. BOX \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 CITY / STATE / ZIP: \_\_\_\_\_ MOBILE PHONE: \_\_\_\_\_  
 SOCIAL SECURITY NUMBER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
 GENDER:  MALE  FEMALE  OTHER: \_\_\_\_\_ ETHNICITY:  HISPANIC  NON-HISPANIC  
 RACE (SELECT ONE):  WHITE/CAUCASIAN  AMERICAN INDIAN  ASIAN  BLACK/AFRICAN AMERICAN  OTHER: \_\_\_\_\_

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/SYMPOM(S):

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

NECK (0= No PAIN):	MID BACK (0= No PAIN):	LOW BACK (0= No PAIN):	_____:	_____:
BEST: _____/10	BEST: _____/10	BEST: _____/10	BEST: _____/10	BEST: _____/10
WORST: _____/10	WORST: _____/10	WORST: _____/10	WORST: _____/10	WORST: _____/10
NOW: _____/10	NOW: _____/10	NOW: _____/10	NOW: _____/10	NOW: _____/10
USUAL: _____/10	USUAL: _____/10	USUAL: _____/10	USUAL: _____/10	USUAL: _____/10

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       | 5. _____ SEXUAL ACTIVITY         | 9. _____ BENDING FORWARD/LIFTING | 16. _____ DRESSING SELF         |
| 2. _____ LYING ON SIDES      | 6. _____ GETTING IN / OUT OF CAR | 10. _____ PROLONGED STANDING     | 17. _____ WALKING               |
| 3. _____ LYING ON STOMACH    | 7. _____ PUSHING / PULLING       | 11. _____ USING A COMPUTER       | 18. _____ COUGH / SNEEZE/ GRUNT |
| 4. _____ TURNING OVER IN BED | 8. _____ UP/DOWN STAIRS          | 12. _____ SITTING/DRIVING/RIDING | 19. _____                       |

**WHAT MAKES THE CONDITION BETTER?** (ICE, ADJUSTMENTS, IBUPROFEN, STRETCHING, ETC.)

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

**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 OR BACK?
- 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?
- ANY PROGRESSIVE WEAKNESS INTO LOWER EXTREMITY?
- ANY UNEXPLAINED WEIGHT LOSS?

**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

**SMOKING STATUS:**

- SMOKER
- NON-SMOKER

**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 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)

**LIST ANY OTHER SELF CARE REMEDIES YOU'VE ATTEMPTED TO ALLEVIATE YOUR CONDITION?** (E.G. MASSAGE, VIBRATION GUN, TOPICAL OINTMENTS OR HOME MEDICAL EQUIPMENT SUCH AS BRACES/SUPPORTS, CERVICAL PILLOW, LOW BACK SUPPORT BELT, STRETCHING, EXERCISING, ETC.)

**DESCRIBE ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS, AND/OR SURGERIES:** (USE MORE PAPER AS NEEDED.)

DATE	DR. NAME	CONDITION(S)	RESULTS
			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS
			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS
			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS

**\*DRUG ALLERGIES:**  NONE -OR-  LIST: \_\_\_\_\_

**Please provide Your:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

**Doctor will gather:**

Temp: \_\_\_\_\_ Resp: \_\_\_\_\_

Pulse: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ ( Sit / Stand)

**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?

**CURRENT PRESCRIPTION MEDICATIONS:**

NAME OF MEDICATION	DOSAGE?	FOR WHAT CONDITION(S)	FREQUENCY (# PER DAY/WEEK)

## 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: \_\_\_\_\_

YES NO

## SOCIAL HEALTH HISTORY

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? \_\_\_\_\_

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

PLEASE DESCRIBE IN MORE DETAIL: \_\_\_\_\_  
\_\_\_\_\_

## PATIENT-CHOICE TREATMENT OPTIONS

**CHECK ALL THE BOXES BELOW THAT CORRESPONDS HOW YOU WOULD LIKE THE DOCTORS TO APPROACH YOUR ISSUE(S):**

- I SIMPLY WISH TO JUST HAVE A FEW ADJUSTMENTS FOR SYMPTOM CONTROL, THEN CALL AS NEEDED.
- I WOULD LIKE THE DOCTORS TO PUT ME ON A TREATMENT PLAN TO HELP ME FULLY RECOVER.
- I AM INTERESTED IN BEING SHOWN ANY NECESSARY STRETCHES +/- EXERCISES TO HELP ME HEAL FASTER.
- I WOULD BE OPEN TO VITAMIN/SUPPLEMENT OR OTHER PRODUCT RECOMMENDATIONS TO HELP MY BODY THROUGH THE HEALING PHASES.
- ONCE I COMPLETE MY INITIAL TREATMENT PLAN, I'M INTERESTED IN A MAINTENANCE ADJUSTMENT SCHEDULE TO SUPPORT MY GAINS.

**PATIENT NOTES:**



## 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 POSSES 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 SHOWN 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

\_\_\_\_\_

\_\_\_\_\_