INDIANA CHIROPRACTIC CENTER

.....Welcome

Personal History

Date: _____

Full Name: _____ Preferred Name: _____
Address: _____ City: _____
State /Prov: _____ Zip/Postal Code: _____ Preferred Language: _____
Home Phone: _____ Birth Date: _____ Age: _____
Cell Phone : _____ Sex: [ ] Male [ ] Female
Social Security # _____ Circle One: Married Single Divorced Widowed
E-mail Address:_____
Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other/ I Decline to Answer
Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
Business Employer: _____ Type of Work: _____
Business Phone: _____ Name of Spouse: _____
Spouse's Employer_____
Type of Work _____ Names and Ages of Children:_____
How were you referred to our office? _____ _____
Name and Number of Emergency Contact: _____ Relationship: _____

Current Health History

Purpose of this Appointment _____
Other Doctors seen for this condition: [ ] Yes [ ] No Who?_____
Type of Treatment: _____ Results: _____
When Did This Condition Begin?_____ Has This Condition Occurred Before? [ ] Yes [ ] No
Is Condition: [ ] Job Related [ ] Auto Accident [ ] Home Injury [ ] Fall [ ] Other_____
Date of Accident: _____ Time of Accident _____
Have You Made a Report of Your Accident to Your Employer? [ ] Yes [ ] No
Are you currently taking any medications? [ ] Yes [ ] No
Medication Name & Dosage/Frequency

_____
_____
_____

Do you have any medication allergies? [ ] Yes [ ] No
Medication Name / Reaction / Onset Date / Comment

_____
_____

Do You Wear a Shoe Lift / Insert? [ ] Yes [ ] No
Do You Suffer From Any Other Condition *Other Than* That Which You Are Now Consulting Us?_____
Name of Your Primary Care Provider?_____ Office Phone #_____

Lifestyle

Do you exercise? [ ]Yes [ ]No How often? (circle) 1X 2X 3X 4X 5X /per week Other: _____
What activities? [ ]Running [ ]Jogging [ ]Weight Training [ ]Cycling [ ]Yoga [ ]Pilates [ ]Swimming
[ ]Other _____
Smoking Status: [ ]Every Day Smoker [ ]Occasional Smoker [ ]Former Smoker [ ]Never Smoked
Do you drink alcohol? [ ]Yes [ ]No How much / week?_____
Do you drink coffee? [ ]Yes [ ]No How many cups / day?_____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____
Blood Pressure: [ ] Normal [ ] Low [ ] High
Weight: _____
Height: _____

Revised as of 11/2016

Past Health History

Please Check and Describe:

Surgery / Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gall Bladder [ ] Ear Tubes/Adenoids
[ ] Broken Bones [ ] Back / Neck Surgery [ ] Other _____

Accidents or Falls: _____

_____

Hospitalizations (Other Than Above): _____

_____

Previous Chiropractic Care: [ ] None [ ] Doctor's Name & Approximate Date of Last Visit _____

Pediatric History for Newborns to 3 Years of Age Only

What was the position of your child in utero?

__Normal (head down) __Posterior __Transverse __Breech

What was the nature of your child's birth?

__Long labor __C-section __Forceps __vacuum __Other _____

Does your baby have any nursing difficulties?

__ R L prefers one side __Weak latch __Other _____

Has your child had any minor or major falls?

__Repetitive falls with walking ___Fall from a height ___Other _____

Is your child crawling? Y or N

Crawling History: __Normal (6 to 11 months) __Army crawl __Drags one leg __Skipped crawling

Does your child have any balance or coordination issues when walking? _____

Health Conditions

Accumulation of Physical, Chemical and Emotional Stressors lead to Nerve Stress on your entire body. This nerve stress leads to a body that has challenges adapting, healing, functioning and feeling good. Slips, falls, accidents and abnormal postural habits lead to spinal misalignments which cause undetected nerve damage. Our food choices and prolonged uses of medications lead to toxicity and chronic emotional stress leads to hormone imbalances (adrenaline/cortisol). It has been extensively documented that accumulated nerve stress will weaken and distort the overall structure of your spine and will negatively impact overall organ function and health. The areas of nerve stress will determine the organs affected and its affect on your body's health.

Have you experienced any of the following in the past or presently? Check all that apply.

Neck = Cervical Spine:

- ❑ Low Energy / Fatigue
- ❑ Neck Pain
- ❑ Headaches
- ❑ Pain into Shoulders/Arms/Hands
- ❑ Numbness/Tingling in Arms/Hands
- ❑ Weakness in Grip
- ❑ Dizziness
- ❑ TMJ Pain / Clicking
- ❑ Colic
- ❑ Coldness in Hands
- ❑ ADD / ADHD
- ❑ Sinusitis
- ❑ Recurrent Colds/Flu
- ❑ Hearing Disturbances
- ❑ Visual Disturbances
- ❑ Thyroid Conditions
- ❑ Allergies/Hay Fever
- ❑ Ear Infections

Lower back = Lumbar Spine:

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Bed Wetting
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Mid/Upper back = Thoracic Spine:

- ❑ Heart Palpitations
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Heart Attacks/Angina
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness Of Breath
- ❑ Pain On Deep Inspiration/Expiration
- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired / Irritable after eating

Consent to Care

I do hereby authorize the doctors of Indiana Chiropractic Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy, diagnostic x-rays, or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal a adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I authorize the doctors of Indiana Chiropractic Center to discuss the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees previously incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor. I permit Indiana Chiropractic Center and their business associates to contact me, and all other responsible parties on my account, on my cell phone or other mobile devices concerning any and all aspects of my account.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

I, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions (s) for which I seek treatment.

Signature_____ Date _____
(If under age 18) Parent's signature