Optimum Family CHIROPRACTIC INC.

PERSONAL INFORMATION

Name: _____ Preferred Name: _____ Date: MM/DD/YYYY
Birthday: MM/DD/YYYY Age: ____
Address: _____
City _____ Prov. _____ Postal Code: _____
Home #: _____ Cell #: _____ Work #: _____
E-Mail Address: _____
Occupation: _____ Employer: _____
Marital Status: S ○ D ○ W ○ M ○ Spouse / Partner's Name: _____

Children

Name _____ Age: ____ Gender: M ○ F ○ Name _____ Age: ____ Gender: M ○ F ○
Name _____ Age: ____ Gender: M ○ F ○ Name _____ Age: ____ Gender: M ○ F ○

Who may we thank for referring you to our office? or How did you choose us?

- ☐ Family/ Friend (name) _____
- ☐ Facebook
- ☐ Website
- ☐ Workshop (which group) _____
- ☐ Health Practitioner _____
- ☐ Walk-in
- ☐ Print Advertisement
- ☐ Other _____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? No ○ Yes ○ Date of last visit: _____
Has a family member previously seen a chiropractor? No ○ Yes ○ if yes, Spouse ___ Child ____
Name of chiropractor: _____
Reason for seeing them: _____
Describe your experience? _____
How frequently did you go for adjustments? _____
What made you decide not to return to see them? _____

IMPORTANT NOTE:

Today's visit will be focusing on assessing the health of your spine and nerve system. Your central nerve system (brain and spinal cord) is the master controller of your body. Everything in your life is processed and controlled by your nerve system, therefore your health and overall quality of life is dependent on proper function and communication. Due to the close relationship with your spine, if your spine is misaligned and degenerating, it can interfere and alter the function of your nerve system (SUBLUXATION). The result of this miscommunication between your brain and body in some cases is pain or discomfort but it can have broader, more serious effects such as energy loss, fatigue, depression, immune problems, digestive problems, high blood pressure and many more. Many times subluxations are affecting your health long before symptoms show up. By continuing to fill out this form, we will understand how subluxations may already be affecting your health and quality of life.

For Office Use Only

CORE:	Hx:	G:
C:		
L:		

HEALTH CONCERNS – FILL IN ALL AREAS Please check (√) all that you have experienced in the last 12 months

- ☐ ADD/ADHD
- ☐ Allergies_____
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Back pain
- ☐ Upper ☐ Mid ☐ Lower
- ☐ Balance/Coordination
- ☐ Bladder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Colds
- ☐ Congestion
- ☐ Constipation/Gas
- ☐ Cysts
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Ear Infections/Aches
- ☐ Eczema
- ☐ Epilepsy/Seizure
- ☐ Eye Pain
- ☐ Focus/Memory Issues
- ☐ Food Sensitivities
- ☐ Gallbladder issues
- ☐ G.I. Issues
- ☐ Hand/Wrist Pain
- ☐ Headaches/ Migraines
- ☐ Heart Disease
- ☐ Hernias
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Insomnia
- ☐ Kidney issues
- ☐ Knee/Ankle/Foot Pain
- ☐ Metabolism issues
- ☐ Neck/Shoulder Pain
- ☐ Pneumonia/Bronchitis
- ☐ Poor Circulation
- ☐ Prostate issues
- ☐ Reflux/Heartburn
- ☐ Reproductive Issues
- ☐ Sensory Processing/ Spectrum Disorder
- ☐ Speech Issues
- ☐ Stress
- ☐ Swollen Tonsils/Adenoids
- ☐ Thyroid issues
- ☐ Tinnitus/Ringing Ears
- ☐ Ulcers
- ☐ Vertigo
- ☐ Vision/Hearing Loss
- ☐ Other:_____

Special Note Have you taken any medication within the last 24 hours? No ○ Yes ○

Please List: _____

Which one of the above is your main concern and brought you to our office? _____

On a scale of 1-10 (10 being severe), how bad is the problem? _____ / 10

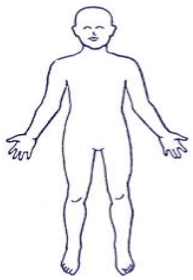
When did it start? _____ How? _____

Is it? getting better ○ getting worse ○ staying the same ○

How would you describe the problem? _____

Are you taking medication for this condition? No ○ Yes ○ Please List: _____

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below (i.e. sharp, dull, burning, tight, throbbing...).



Front _____

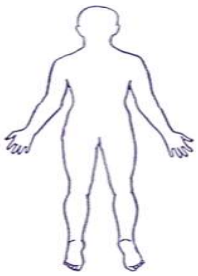
_____

_____

Back _____

_____

_____



What makes it worse? _____

What makes it better? _____

What else have you tried and what were the results? _____

What parts of your life is this condition interfering with: Work ☐ Sleep ☐ Exercise ☐ Family ☐ Social ☐

Positive mental attitude ☐ Hobbies ☐ Other _____

_____

Which part of your life is most important for you to get back to ASAP? _____

Beyond feeling better, what are 3 reasons you want to be healthier?

1) _____

2) _____

3) _____

Fill out ALL detail below for the NEXT 3 most concerning conditions that you checked off:

#1:_____

On a scale of 1-10 (10 being severe), how bad is the problem? _____ / 10

When did it start?_____ How?_____

Is it? getting better ○ getting worse ○ staying the same ○

How would you describe the problem?_____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

#2:_____

On a scale of 1-10 (10 being severe), how bad is the problem? _____ / 10

When did it start?_____ How?_____

Is it? getting better ○ getting worse ○ staying the same ○

How would you describe the problem?_____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

#3:_____

On a scale of 1-10 (10 being severe), how bad is the problem? _____ / 10

When did it start?_____ How?_____

Is it? getting better ○ getting worse ○ staying the same ○

How would you describe the problem?_____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

Please list ALL OTHER medications you are currently taking and for what reasons: _____

_____

Your Injury/ Surgery History

Have you had any surgery? (Please include all surgeries including C-Section)

1. Type_____ Date:_____

2. Type_____ Date:_____

Accidents and / or injuries: auto, work related or other (especially those related to your present problems).

1. Type:_____ Date:_____ Hospitalized: ○ No ○ Yes

2. Type:_____ Date:_____ Hospitalized: ○ No ○ Yes

Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically. The risk of injuries and complication is so small that Chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

1. Research shows that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.
2. While extremely rare, there have been reports of ligament sprains and rib fractures.

☐ I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.

☐ I understand that research and training is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes and understand that audio or video recordings may occur from time to time. (Your personal privacy is very important to us. We will not release any personal information).

☐ I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office.

Your name: _____ Signature:_____ Date:_____

Witness: _____

SAVE RESET PRINT EMAIL