

TEITELBAUM CHIROPRACTIC

FEEL BETTER, MOVE BETTER, LIVE BETTER.

WELCOME! WE'RE GLAD YOU'RE HERE.

TODAY'S DATE:

FIRST NAME:

LAST NAME:

GENDER:

MARITAL STATUS: S M D W PARTNER

BIRTHDATE:

HEIGHT: WEIGHT:

OF CHILDREN:

CHILDREN'S AGES:

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

CELL PHONE:

EMAIL:

WHOM CAN WE THANK FOR REFERRING YOU?

PLEASE GIVE YOUR INSURANCE CARD TO SONIA

OCCUPATION: FULL TIME / PART TIME

PLEASE DESCRIBE YOUR TYPICAL WORK DAY:

HOW CAN WE HELP YOU?

ARE YOUR SYMPTOMS CONSTANT? Y/N WHEN DID YOU FIRST NOTICE CURRENT SYMPTOMS?

ARE YOU HERE AS A RESULT OF AN ACCIDENT? WORK AUTO OTHER

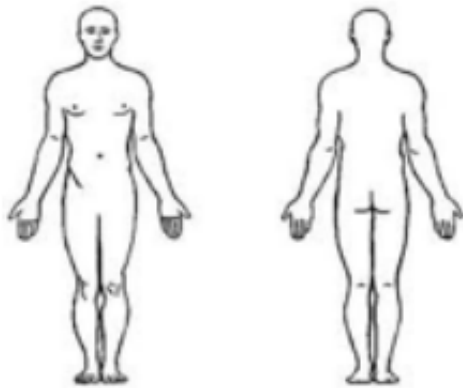
HOW EXTREME ARE YOUR SYMPTOMS?

1 2 3 4 5 6 7 8 9 10
mild moderate agonizing

EXPLAIN THE PAIN

FOR THE FOLLOWING QUESTIONS, PLEASE CIRCLE ALL THAT APPLY

PLEASE CIRCLE AREAS AFFECTED ON THE DIAGRAM BELOW



WHAT DOES IT FEEL LIKE?

- NUMBNESS
- TINGLING
- STIFFNESS
- DULL
- ACHING
- CRAMPING
- NAGGING
- SHARP
- BURNING
- SHOOTING
- THROBBING
- STABBING
- SWELLING
- OTHER

WHAT MAKES IT BETTER/WORSE?

- SITTING
- STANDING
- WALKING
- LYING DOWN
- READING
- MORNING
- NIGHT
- OTHER

WHAT HAVE YOU TRIED TO RELIEVE YOUR SYMPTOMS?

- PRESCRIPTION MEDICATIONS
- OVER THE COUNTER DRUGS
- HOMEOPATHIC REMEDIES
- PHYSICAL THERAPY

- SURGERY
- ACUPUNCTURE
- MASSAGE
- CHIROPRACTIC

- ICE
- HEAT
- OTHER

ACTIVITIES OF DAILY LIVING

	NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT
SITTING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RISING OUT OF CHAIR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STANDING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WALKING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LYING DOWN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BENDING OVER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CLIMBING STAIRS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
USING A COMPUTER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GETTING IN/OUT OF CAR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DRIVING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LOOKING OVER SHOULDER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CARING FOR FAMILY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GROCERY SHOPPING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HOUSEHOLD CHORES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LIFTING OBJECTS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
REACHING OVERHEAD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SHOWERING/BATHING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GETTING DRESSED	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EXERCISING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
YARD WORK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GETTING TO SLEEP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STAYING ASLEEP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LOVE LIFE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CONCENTRATING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

DR JAN'S NOTES

ILLNESSES

- AIDS
- ALCOHOLISM
- ARTERIOSCLEROSIS
- CANCER
- DIABETES
- GLAUCOMA
- GOUT
- HEART DISEASE
- HEPATITIS
- HIV
- MEASLES
- MULTIPLE SCLEROSIS
- STROKE

OPERATIONS

- APPENDIX
- BYPASS
- CANCER
- COSMETIC
- EYE
- HYSTERECTOMY
- PACEMAKER
- TONSILLECTOMY
- VASECTOMY
- SPINE SURGERY
- OTHER

INJURIES

- BROKEN BONE
- SPINE DISORDER
- NERVE DISORDER
- KNOCKED UNCONSCIOUS
- ACCIDENT
- USED CANE OR CRUTCHES
- USED NECK OR BACK BRACE

ALLERGIES

DO YOU HAVE ALLERGIES? Y N
PLEASE LIST:

TREATMENTS

- ACUPUNCTURE
- ANTIBIOTICS
- BIRTH CONTROL
- CHEMOTHERAPY
- CHIROPRACTIC
- DIALYSIS
- HERBS
- HOMEOPATHY
- HORMONE REPLACEMENT
- PHYSICAL THERAPY
- INHALER
- ALLERGY SHOTS
- NUTRITIONAL SUPPLEMENTS
- PRESCRIPTION MEDICATIONS

OTHER HEALTH CONCERNS

PLEASE MARK ANY CONDITION YOU CURRENTLY HAVE OR HAVE HAD

MUSCULOSKELETAL

- OSTEOPOROSIS
- KNEE INJURIES
- ARTHRITIS
- FOOT/ANKLE PAIN
- SCOLIOSIS
- SHOULDER ISSUES
- NECK PAIN
- ELBOW/WRIST PAIN
- BACK PROBLEMS
- TMJ ISSUES
- HIP DISORDERS
- POOR POSTURE

DIGESTIVE

- ANOREXIA
- BULIMIA
- ULCER
- FOOD SENSITIVITIES
- HEARTBURN
- CONSTIPATION
- DIARRHEA

NEUROLOGICAL

- ANXIETY
- DEPRESSION
- HEADACHES
- MIGRAINES
- DIZZINESS
- PINS + NEEDLES
- NUMBNESS

CARDIOVASCULAR

- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- HIGH CHOLESTEROL
- POOR CIRCULATION

RESPIRATORY

- ASTHMA
- APNEA
- EMPHYSEMA
- SHORTNESS OF BREATH
- PNEUMONIA

OTHER

- THYROID
- IMMUNE DISORDERS
- RINGING IN EARS
- BEDWETTING
- PROSTATE ISSUES
- POOR APPETITE
- SUDDEN WEIGHT GAIN

ARE THERE ANY MAJOR ILLNESSES IN YOUR FAMILY HISTORY?

HEALTH AND NUTRITION HABITS AND GOALS

	# PER DAY	# PER WEEK
ALCOHOL USE	<input type="text"/>	<input type="text"/>
COFFEE USE	<input type="text"/>	<input type="text"/>
SODA USE	<input type="text"/>	<input type="text"/>
TOBACCO USE	<input type="text"/>	<input type="text"/>
FAST FOOD	<input type="text"/>	<input type="text"/>

PAIN RELIEVERS **Y/N**
PRESCRIPTION PILLS **Y/N**
OTC PILLS **Y/N**
PLEASE LIST:

STRESS LEVEL: **HIGH AVERAGE LOW**

HOURS OF SLEEP PER NIGHT?

WATER INTAKE

OF 8OZ GLASSES PER DAY:

HAVE YOU EVER SUFFERED A FALL OR OTHER SERIOUS INJURY? **Y/N** WHAT AGE?
PLEASE DESCRIBE:

HOW DO YOU CARE FOR YOURSELF?

DO YOU HAVE ANY HOBBIES?

	POOR	FAIR	PRETTY GOOD	EXCELLENT
PHYSICAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NUTRITIONAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EMOTIONAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PRAYER OR MEDITATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FINANCIAL PEACE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- * I realize that an X ray might be hazardous to an unborn child and to the best of my knowledge I am not pregnant.
- * I grant permission for you to call, text, or email to verify appointments or share health information as an extension of my care.
- * The information I have provided is complete and truthful. I have not misrepresented my current condition in any way.

If the patient is a minor, please print the child's name: _____

SIGNATURE _____

DATE _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____