PATIENT DETAILED INFORMATION

Last Name First Name MI "Nickname"

Address DOB

City State Zip/Postal Code E-mail

Home Phone Cell Phone Work phone SS # (Last 4)

Emergency contact Primary contact # Relationship to Patient

Marital Status:

- ☐ Single ☐ Married ☐ Widowed ☐ Divorced

How did you hear about us?

- ☐ Word of mouth ☐ Facebook ☐ Practitioner Referral
- ☐ Drive by ☐ Google ☐ Class/Workshop

*If by word of mouth, whom may we thank for referring you to us? _____

Health Complaints

What is your PRIMARY complaint? _____
How long have you been experiencing this primary complaint? _____
Has this progressed over time? (worse/same/better)
What do you think caused your primary complaint?

What movements or activities tend to increase your pain?

1. _____ 3. _____
2. _____ 4. _____

What movements or activities tend to decrease your pain?

1. _____ 3. _____
2. _____ 4. _____

Are there movements or activities you typically avoid?

1. _____ 3. _____
2. _____ 4. _____

What activities are you no longer doing that you would like to do?

1. _____ 3. _____
2. _____ 4. _____

Is there anything about your lifestyle that you think contributes to your pain?

_____

List any other secondary complaints you are currently experiencing. (in order of severity)

1. _____ 3. _____
2. _____ 4. _____

Stress and anxiety can cause or enhance your secondary complaints.

Do you feel that stress influences your pain? (Yes or No)

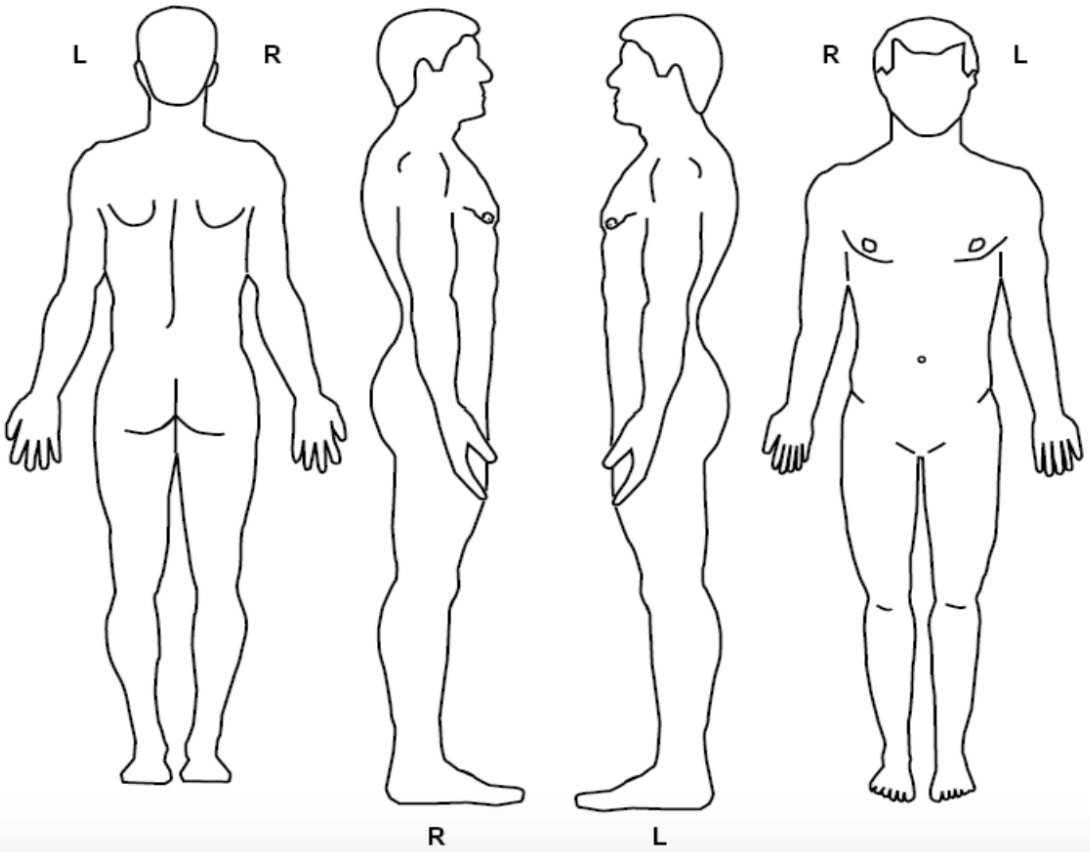
In the last 60 days, how often have you felt "stressed" or "overwhelmed"?

☐ Never ☐ Sometimes ☐ Fairly Often ☐ All the time

Do you feel that you manage your stress well? (Yes or No)

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness (N) **Tingling (T)** **Burning Pain (B)** **Stabbing Pain (S)** **Aching Pain (A)**



Lifestyle & Nutritional Habits

Occupational History:

Do you work? ☐ Yes ☐ No ☐ Disability ☐ Retired

Occupation(s):_____

Daily Habits:

On average, how many hours of television do you watch per day?

☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

On average, how many hours per day do you use a computer at work or at home?

☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

On average how many hours per day do you ride in a car or other vehicle?

☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

On average how many hours of sleep do you get per night?

☐ <6 ☐ 7 ☐ 8 ☐ >8

Do you exercise? (Yes) or (No)

If yes, how often?

☐ Daily ☐ 3-5x/wk. ☐ 2x/wk. ☐ 1x/wk.

If yes, how long are your workouts?

☐ < 0.5 hour ☐ 0.5-1hour ☐ 1-2hours ☐ >2 hours

What are your exercise activities? (mark all that apply)

☐ Walking
☐ Jogging/Running
☐ Swimming
☐ Biking
☐ Rowing
☐ Hiking
☐ Resistance Training
☐ Stretching
☐ Yoga/Pilates
☐ Intramural Sports

Do you smoke tobacco? (Yes or No) If yes, How often?_____ How much?_____

Do you use recreational drugs? (Yes or No)

How many cups of water do you drink per day?

☐ 1-3 ☐ 4-6 ☐ 7-8 ☐ >8

How many servings of alcohol do you drink per week?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many cups of coffee do you drink per week?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink per week?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

Dietary Habits:

Have you ever made changes in your eating habits due to your health? (Yes or No)

What does your diet primarily consist of? (mark all that apply)

☐ Breads & cereals
☐ Pastas & rice
☐ Lean Protein (chicken/fish)
☐ Red Meat
☐ Dairy (milk, cheese, etc.)
☐ Fruits
☐ Vegetables
☐ Healthy Fats
☐ Processed/packaged foods
☐ Cookies, crackers, pretzels
☐ Candy
☐ Soda/Energy Drinks

All Medical History is valuable. Please indicate with a "P" if it is a Personal Medical History, or "F" if it is Family Medical History

Medical History

____ Addiction
____ AIDs/HIV+
____ Allergies/hay fever
____ Alzheimer's disease
____ Anemia
____ Arthritis:
Specify _____
____ Artificial bone/joints
____ Asthma
____ Autoimmune disease
____ Blood pressure problems
____ Cancer
____ Carpal tunnel syndrome
____ Chemical dependency
____ Chicken pox
____ Cholesterol, elevated
____ Chronic fatigue syndrome
____ Circulatory problems
____ Constipation
____ Depression
____ Diabetes
____ Diarrhea
____ Dizziness
____ Drug addiction
____ Eating disorder
____ Epilepsy
____ Eyes, ears, nose, throat problems
____ Emphysema
____ Fatigue
____ Fibromyalgia
____ Food intolerance
____ Gastric reflux disease
____ Genetic disorder
____ Glaucoma
____ Gout
____ Headaches
____ Heart disease
____ Hernia
____ Herniated disk
____ Infection, chronic
____ Inflammatory bowel disease
____ Kidney or bladder disease
____ Liver or gallbladder disease
____ Measles
____ Mumps
____ Migraine headaches
____ Multiple sclerosis
____ Neurological problems (Parkinson's, paralysis)
____ Obesity
____ Osteoporosis
____ Pneumonia
____ Psychiatric care
____ Recent Weight loss or gain
____ Sexually impotency
____ Sexually transmitted disease
____ Seizures
__ Sinus problems
____ Skin problems
____ Stroke
____ Thyroid trouble
____ Tuberculosis
____ Tumors, growths
____ Ulcer
____ Urinary tract infection
____ Varicose veins
____ Varicella/Shingles
____ Other _____
_____

Exercise
Do you exercise?
Yes ____ No_____
Type:_____
Frequency:_____

Health Habits
□ Tobacco_____ Type
□ Alcohol _____ /week
□ Caffeine_____ /week
□ Water _____ oz. per day

Medical (Men)
____ BPH
____ Decreased sex drive
____ Infertility
____ Prostate cancer
____ STD
____ Other _____
_____

Medical (Women)
____ Breast cancer
____ Breast Implants
____ C-section
____ Decreased sex drive
____ Endometriosis
____ Fibrocystic breasts
____ Fibroids/ovarian cysts
____ Infertility
____ Menopause
____ Menstrual irregularities
____ Pelvic inflammatory disease
____ PMS
____ STD
____ Surgical menopause
____ Vaginal infections
____ Other _____
_____

Form of birth control _____
#of children _____
#of pregnancies _____
Are you pregnant?
#of weeks _____
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)_____
_____

Any recent illnesses or infections? (if yes, explain): _____
Any known allergies or sensitivities? _____
List any broken bones or dislocations. (include location and date): _____
Have you suffered any head injuries? (including concussions): _____
Were you ever knocked unconscious? (if yes, please explain): _____

Surgical History
Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws) If yes, please explain:
_____
List all of the previous surgical procedures as they pertain to you: _____
_____

Medications, Vitamins, Supplements

Please list any vitamins or supplements you are currently taking.

Please list any prescription or over-the-counter medications you are currently taking and the condition for which they are for.

Injuries

List any (even minor) motor vehicle collisions that you have been involved in as either a driver or passenger. Start with the most recent.

Type of Collision	Injury & Treatment Received	Date of Injury

List any athletic injuries that you have experienced below. Start with the most recent.

Type of Injury	Treatment Received	Date of Injury

List any other injuries that you have experienced below. .Start with the most recent.

Type of Injury	Treatment Received	Date of Injury

I understand and agree to the following:

It is my responsibility to complete the clinic's forms accurately and provide the most up to date information.

It is my responsibility to notify the doctor if any of the information has changed or requires updating.

Patient Name (print)	Patient Signature	Date

Parent/Guardian Name (print)	Parent/Guardian Signature	Date

HEALTH CARE AUTHORIZATION

As of April 14, 2003, the Federal Government requires a patient's signature to authorize being contacted by phone, mail, etc. This is a result of the Health Insurance Portability Act (HIPAA). The goal is to protect your personal health information.

PRINT PATIENT NAME _____
Last **First** **Middle**

Date of Birth _____ / _____ / _____

Specific Authorizations:
I give permission for Origins Chiropractic and Wellness to contact me by e-mail, phone or leave message on my voice-mail regarding my appointments and status of health. I also give permission to use my name and address to mail office and e-mail newsletters, referral cards, postcards, holiday related cards or information about health related issues.

Initial Here: _____

Patient Rights:

1. **You have the right to refuse to sign this authorization.** If you refuse to sign this Authorization, Origins Chiropractic and Wellness will not refuse to provide treatment.

2. **You have the right to revoke this authorization, in writing at any time.** You may revoke this Authorization by mailing or hand delivering a written notice to the Privacy Official of Origins Chiropractic and Wellness. The written notice should contain your name, Social Security number and date of birth. State your intent to revoke this authorization, then sign and date it. Once received, the Privacy Official will revoke the authorization.

3. **You have the right to a copy of this authorization.**

Patient Signature _____ **Date:** _____

Personal Representative Signature (if applicable) _____

For Office Use Only

Expiration-
This Authorization shall expire in 7 years. Expiration Date: _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

Chiropractic healthcare seeks to improve health through natural means without the use of drugs or surgery. This helps the body maximize its inherent healing ability. The success of the doctor of chiropractic's procedure often depends on underlying causes, patient compliance, as well as other spinal and physical conditions.

ADJUSTMENTS

The doctors utilize various techniques to adjust the spine. The techniques used are non-rotary done with hands or an instrument. Adjustments done by hand are considered high velocity low amplitude, non-rotary. Instrument adjustments are low force done to the upper cervical spine.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient, you agree to give the doctor permission and authority to care for you in accordance with the chiropractic tests and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects of pathologies may render a patient susceptible to injury. The doctor will not provide healthcare if he is aware that such care may be contraindicated. Again, it is your responsibility to tell the doctor everything you know about your health conditions, which would otherwise not come to the attention of the doctor. The doctor of chiropractic provides a specialized, non-duplicating health service, but he is also available to work with other types of healthcare providers.

RESULTS

As a patient in this office, you are acknowledging that your doctor or his assistants have given no guarantee as to the results that may be obtained from you care. Chiropractic care is not a treatment of disease, but a system of correcting vertebral subluxations. The doctor also wants it understood that although he does not utilize rotary manipulation, he is in no way indicating that his procedure is superior to his fellow chiropractors.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and/or other healthcare professionals for the sake of case management. As a patient, you are giving the doctor permission to use his best judgement for when to allow an observer in the room or when it is necessary to release the above patient information. I also give permission for the doctor to use information from my examination to help evaluate statistics for research, as long as my name is not used.

TO THE PATIENT

Please discuss any question or problems with the doctor before signing this statement of policy. I have had the above explained to me and after reading it, I understand the foregoing and give my consent. I acknowledge that the doctor reserves the right to discontinue and/or refuse care in the event that it becomes unsafe to render care or I become noncompliant with the current care plan.

Date_____ Signature_____