

ENERGETIC CHIROPRACTIC

health history form

Please fill out this form as completely and accurately as possible.

Today's Date

About You

Name		
Age		
Date of Birth		
Home Address		
City	State	ZIP
Home Phone	Work Phone	
Cell Phone	E-mail Address	
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Emergency Contact	Phone	
Occupation		
Employer Name		
Business Address		
City	State	ZIP
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Separated		
Spouse/Partner's Name		
Names and Ages of Children		
How did you hear about Energetic Chiropractic?		
If you were referred to Energetic Chiropractic, whom can we thank?		

Health Care Practitioner History

Have you ever received chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, approximate date of last visit
Name of chiropractor
Reason for care <input type="checkbox"/> Injury/Crisis (symptom focused) <input type="checkbox"/> Wellness (focused on health and peak performance) <input type="checkbox"/> Other
Reason for ending care
Are you currently receiving medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, for what?
Please list any medications you are currently taking (prescription and over the counter), reason for taking and for how long.
<i>NOTE: It is imperative that you list all medications as they may have an influence on your care in this office</i>
Have you consulted or do you regularly consult any of the following practitioners? (Check all that apply)
<input type="checkbox"/> Naturopath <input type="checkbox"/> Acupuncturist <input type="checkbox"/> Homeopath <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Psychotherapist <input type="checkbox"/> Energy Healer <input type="checkbox"/> Dentist
Reason why?

Your Health Profile

As a full spectrum Chiropractic office, we focus on your body's ability to function optimally and to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of optimal health and wellbeing into the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and compromise one's potential for optimal health. Most often the effects are gradual and not even felt until they become more serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY	Did your mother smoke/drink/do drugs during pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Were you vacuum extracted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Were you a forceps delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did your mother have a C-section?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did your mother have an epidural/medication during labor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Was labor Induced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
CHILDHOOD YEARS	Did you have any childhood illnesses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did you have any serious falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Were you active in sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did you use drugs or alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did you have any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did you have any broken bones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Were you involved in any car accidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Did you experience any other trauma (physical or emotional)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Were you vaccinated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	As a child, were you under regular chiropractic care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Adult History (18 To Present)

Do / did you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do / did you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do / did you use recreational drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do / did you use prescription or over the counter medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you consume caffeine / sugar / artificial sweetener?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been in any accidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do / did you play sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do / did you participate in extreme sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other...	<hr/> <hr/> <hr/> <hr/>	

Quality of Life

How would you describe your...

- ...occupational stress level? Low Moderate High
- ...personal stress level? Low Moderate High
- ...physical health? Excellent Good Poor
- ...mental/emotional health? Excellent Good Poor
- ...overall "quality of life"? Excellent Good Poor

Do you exercise regularly? If yes, what type and how often?

Do you take nutritional supplements? If yes, please list:

Do you follow a special dietary regime? If yes, describe:

Goals for Care

People choose to receive chiropractic care for many different reasons. What best describes your choice? (Check all that apply)

- Relief from your pain or symptoms To experience a new level of health and wellbeing
- To be more connected to your body Not sure
- To optimize your function and performance Other:

Addressing the Issues that Brought You to the Office

If you do not currently have a complaint and you are here for the chiropractic wellness experience, please check (✓) here and skip to the next section.

Briefly describe your **chief area of complaint**, including how it started: _____

Date of Onset ____ / ____ / ____

Please describe the quality of the problem (Check all that apply):

- Deep Dull Achey Throbbing Stabbing
- Sharp Numb Tingling Cramping Travels

How often are you aware of the problem? (Check the most appropriate option):

- Constant (75%-100%) Frequent (51%-75%) Occasional (26%-50%) Intermittent (0%-25%)

Since the onset of the problem, is it (Check the most appropriate option):

- Getting better Getting worse About the same Coming and going

What makes it better? _____

What makes it worse? _____

Grade the Intensity of the problem (Circle): 0 1 2 3 4 5 6 7 8 9 10

Briefly describe your **second area of complaint**, including how it started: _____

Date of Onset ____ / ____ / ____

Please describe the quality of the problem (Check all that apply):

- Deep Dull Achey Throbbing Stabbing
- Sharp Numb Tingling Cramping Travels

How often are you aware of the problem? (Check the most appropriate option):

- Constant (75%-100%) Frequent (51%-75%) Occasional (26%-50%) Intermittent (0%-25%)

Since the onset of the problem, is it (Check the most appropriate option):

- Getting better Getting worse About the same Coming and going

What makes it better? _____

What makes it worse? _____

Grade the Intensity of the problem (Circle): 0 1 2 3 4 5 6 7 8 9 10

If applicable, please illustrate the location of your current complaints on the diagram below:



Symptoms

Please check (✓) all symptoms you have ever experienced, even if they do not seem related to the reason for your current visit

- | | | | | | |
|---|--|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Rashes/Excema |
| <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Irritability | <input type="checkbox"/> Fever | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Urinary changes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Eating disorders | |

The information I have provided on this form is true and accurate to the best of my knowledge and I agree to allow Dr. Jason Reinhold to examine me for further evaluation.

Patient / Guardian Signature

Date

Financial Agreement

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Please select your form of payment.

Cash Check Credit Card HSA FSA

Patient / Guardian Signature

Date

Terms of Acceptance

When a patient accepts chiropractic care, it is essential for both the patient and the chiropractor to be working towards the same objective. It is only when the patient understands the objective that they will be able to attain it. This will prevent any confusion of disappointment.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease.

Interference to the function of the nerve system distorts the clear communication of energy and information between the brain and the body, lessening one's innate potential to achieve optimal health.

Adjustments are specific force applications that facilitate the release of nerve system interference to enhance the communication of energy and information between the brain and the body.

Chiropractic is not a substitute, an alternative, or a preventative form of medicine. We do not offer to diagnose or treat any disease or condition. The only objective of this office is to facilitate the optimal function of the Nerve System and to support you and your body in integrating this process. However, if during the course of chiropractic care, non-chiropractic or unusual findings are encountered, these will be brought to your attention. If you desire any advice, diagnosis, or treatment for those findings, I encourage you to seek the council of a medical disease care specialist.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient / Guardian Signature

Date

Witness Signature (Office Staff)

Date

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic working at this office.

I understand and I am informed that chiropractic care, while offering considerable benefit, like all forms of health care, there is also an associated level of risk. The types of complications that have been reported secondary to chiropractic care include, but are not limited to, fractures, irritation of a disc condition, sprain/strain injuries, dislocations, and rarely, a vertebral artery injury that could lead to stroke.

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 known, is in my best interest.

I have had the opportunity to discuss with the doctor of chiropractic and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

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

Patient Name (Please Print)

Patient / Guardian Signature

Relationship to Patient

Date

Witness Signature (Office Staff)

Date

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Please Print)

Patient / Guardian Signature

Relationship to Patient

Date