Chapin Chiropractic Center

Confidential Patient Information

Name_____ Today's Date:_____

Date of Birth_____ Age_____ Gender M or F Marital Status_____ # Children____

Address_____
Address *City* *State* *Zip Code*

Home Phone _____ Cell Phone_____ Email_____

Your Occupation *Company Name* *City* *Work Phone*

Spouse or Guardian's Name *Occupation* *Company Name* *City*

How did you hear about us?_____

Do you have health insurance? □Yes □No Company_____
If yes, please present your card(s) to the office manager for processing.

BRIEFLY DESCRIBE YOUR HEALTH ISSUE(S)_____

When did it start?_____ What caused it?_____

What makes it better?_____ What makes it worse?_____

What percentage of each day does it currently bother you? (Circle one) 0% 25% 50% 75% 100%

What would you like to do but can't because of this problem?_____

List other health care professionals seen for this condition _____

PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS
- □ **Recent accident** such as a fall, whiplash, or blow to the head
- □ Muscle spasms
- □ Numbness or tingling of hands or feet or radiating pain
- □ Headaches
- □ Migraines
- □ Depression
- □ Anxiety
- □ Dizziness
- □ Vision problem
- □ Nausea
- □ Restriction of movement
- □ Sleeping trouble
- □ Asthma or breathing problem
- □ High blood pressure
- □ Hearing problem
- □ Convulsions/epilepsy
- □ Heartburn/Acid Reflux
- □ Digestive trouble
- □ Menstrual problems
- □ Sinus problems
- □ Difficulty with stress
- □ Spinal disorder
- □ Shoulder, arm or hand problem
- □ Hip, Leg or foot problem
- □ Jaw/mouth problem

DIAGNOSED CONDTIONS
- □ Born with bone or joint disorder
- □ Degenerative arthritis
- □ Rheumatoid arthritis
- □ Compression fracture
- □ Heart attack or heart disorder
- □ History of stroke or aneurysm
- □ Cancer
- □ Diabetes
- □ Gout
- □ Lupus
- □ Ankylosing spondylitis
- □ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- □ 3 or more months of steroid medications or intravenous drugs (past or present)
- □ Tuberculosis
- □ Hepatitis B or HIV infection
- □ Multiple sclerosis
- □ Thyroid or hormone disorder

OTHER CONDITIONS
- □ _____
- □ _____
- □ _____
- □ _____

SPECIFIC PAIN IN THE BODY
- □ Neck pain with difficulty swallowing
- □ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- □ Leg pain that worsens with exercise
- □ Numbness of inner thighs
- □ Back pain with urinary problems
- □ Severe pain that interrupts sleep
- □ Constant pain that doesn't improve by changing positions or by lying down

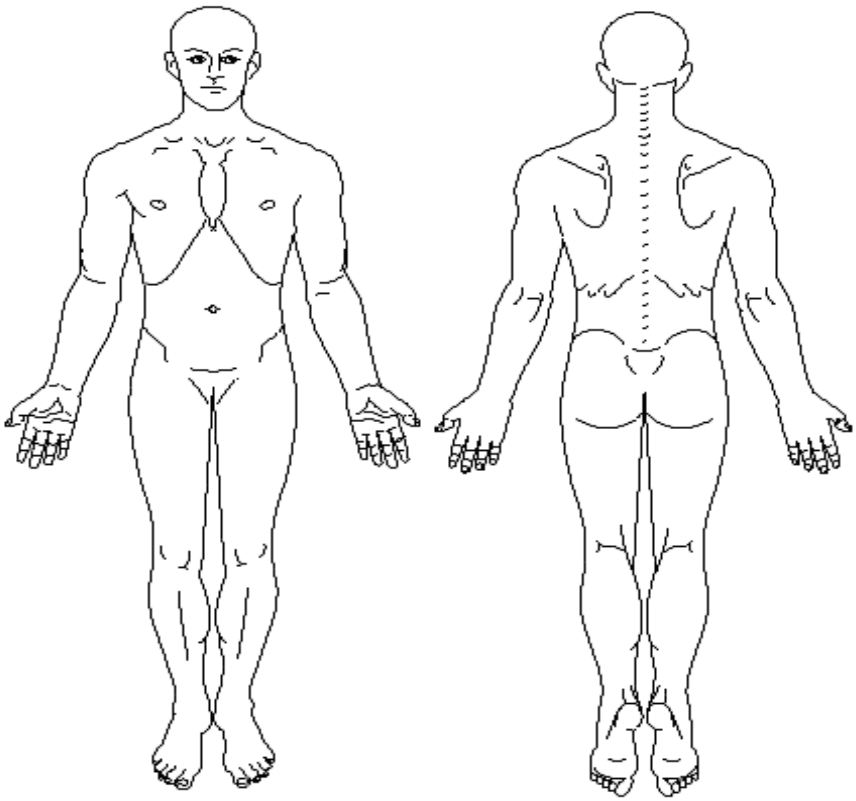
SPECIFIC CURRENT CONDITIONS
- □ Poor balance when walking or standing
- □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- □ Memory loss after injury
- □ Recent, unexplained weight loss
- □ Recent progressive muscle weakness or shaking
- □ Recent or current fever over 102°F
- □ Loss of bowel or bladder control

-Please Continue on Page 2-

Name:_____ Date:_____

PAIN DRAWING

SHADE IN WITH A PEN ALL AREAS YOU HAVE PAIN.
(Don't forget to include the head or areas of lesser pain).
Use small x's to show any areas of numbness or tingling



Please mark on the line, the pain level that most accurately represents your pain for each body area:

		0	1	2	3	4	5	6	7	8	9	10	
				neck				***low back***					
Example:	No pain	|		**X**				**X**				|	Unbearable
Right now:	No pain	|										|	Unbearable
Average Pain:	No pain	|										|	Unbearable
At best & worst:	No pain	|										|	Unbearable

-Please Continue to Page 3-

(Confidential Patient Information Continued)

NAME:_____

FAMILY HISTORY (Circle) Spine problems Autoimmune disorders Arthritis Cancer Diabetes Heart disease Kidney disease Mental illness Seizures Other:_____

Last known: Height_____ Weight_____ **Are you pregnant?** □Yes □No

Describe any **surgeries** or hospitalizations you've had and the dates_____

_____

Current Medications_____

Personal Medical Physician_____ Phone _____

How would you rate your diet?_____ What kind of exercise do you do weekly?_____
What do you do to mentally de-stress?_____

Do you feel you have a pretty good understanding of what CHIROPRACTIC is and how we treat? □Yes □Maybe □No

What are you currently doing to keep you and your family's spines healthy?_____

Consent to Evaluation and Treatment
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Matthew Nelson DC. and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Nelson. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.
I also understand that in the event my insurance fails to pay for all services provided by Dr. Nelson, that I am ultimately responsible to do so in a timely manner.

Our Privacy Policy
Chapin Chiropractic is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Nelson may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

Patient or Guardian's Signature_____ **Date** _____