FOOTHILLS FAMILY CHIROPRACTIC

CHIROPRACTIC NEW PATIENT HEALTH HISTORY INTAKE

Full Name: _____ **Date of Birth:** _____

Current Condition:

Main Concern that brings you to our office: _____

When did this concern begin? _____

_____

When are your symptoms better? ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ NO CHANGE

When are your symptoms worse? ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ NO CHANGE

What makes your symptoms better? _____

What makes your symptoms worse? _____

How would you describe the pain?

☐ DULL ☐ ACHY ☐ SHARP ☐ SHOOTING ☐ TINGLING ☐ NUMB

OTHER

Does the pain radiate anywhere? Describe:

What is the severity of your pain? (0=No Pain & 10=Extreme Pain)

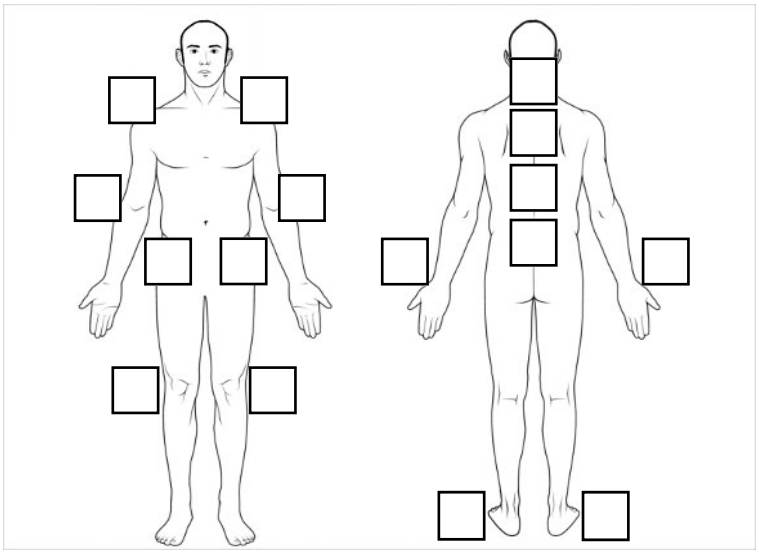
How often do you experience this pain? ☐ SPORADIC ☐ OCCASIONAL ☐ INTERMITTENT ☐ CONSTANT

Have you had this condition before? ☐ YES ☐ NO

If yes, please explain:

If yes, why do you feel this continues to happen to you?

Other doctors seen for this concern:



Please indicate on this diagram any areas of concern:

Physical History:

Have you had any impacts or falls that you feel may have injured your spine?

Please explain: _____

Broken Bones? _____

Surgeries? _____

Are you active in any particular sports?

Do you exercise? ☐ DAILY ☐ 4-5X WEEK ☐ 2-3X WEEK ☐ MONTHLY ☐ NEVER

Have you ever been in a vehicular collision? (Please list date(s) and severity):

Have you ever had physiotherapy? ☐ YES ☐ NO Type/Area of injury?:

Do you have a Neuropath? ☐ YES ☐ NO Name, Date of last visit:

Are you currently taking and prescription OR over-the-counter medication?
(Please list names, frequency of use, condition taken for):

_____

Are you currently taking any herbs, nutritional supplements or natural remedies? Describe:

Daily water intake:

Do you smoke? ☐ YES ☐ NO If yes, How much?

Have you ever been on any elimination diets for food tolerance (ex. Gluten Free)? ☐ YES ☐ NO

Please CHECK any conditions you currently suffer from:

☐ Crohn's ☐ Cancer Type: ☐ Fibromyalgia ☐ Ankylosing Spondylitis

☐ Diabetes ☐ Rheumatoid Arthritis ☐ Colitis ☐ Osteoarthritis ☐ Polio ☐ Heart Disease

☐ HIV/AIDS ☐ Hepatitis ☐ Lupus ☐ Shingles ☐ Scoliosis ☐ Gout ☐ Depression

☐ Loss of Sleep ☐ Osteoporosis List any past conditions:

Please indicate any family history conditions and previous chiropractic care:
(Ex. Cancer, Diabetes, Heart Problems, Connective Tissue Disorder, Arthritis, Back Pain)

Father:

Mother:

Brother(s):

Sister(s):

Have you ever received spinal adjustments from a chiropractor? ☐ YES ☐ NO

If yes, for how long were you receiving the adjustments?

Doctors name: Date of last visit:

If you stopped, why did you stop going?:

Please check (✓) any conditions that have occurred in the past 6 months. Please underline any symptoms that were a problem in the past 2 years.

HEAD:

- ☐ Headache ☐ Light Sensitivity
- ☐ Migraine ☐ Dizziness
- ☐ Head feels heavy ☐ Pain in ears
- ☐ Loss of memory ☐ Ringing in ears
- ☐ Fainting ☐ Loss of balance
- ☐ Blurred vision ☐ Loss of taste
- ☐ Loss of hearing

NECK:

- ☐ Pain with movement ☐ Muscle spasms
- ☐ Pain with turning ☐ Grinding/popping
- ☐ Pain looking up ☐ Arthritis
- ☐ Pain looking down
- ☐ Pinched nerve
- ☐ Neck feels out of place

SHOULDERS:

- ☐ Pain in joints (LEFT/RIGHT)
- ☐ Pain across shoulders
- ☐ Unable to raise arm above shoulder
- ☐ Unable to raise arm above head
- ☐ Rotator cuff tear ☐ Muscle spasms
- ☐ Pinched nerve ☐ Tension in shoulders

MID BACK:

- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain ☐ Muscle spasms
- ☐ Dull ache ☐ Kidney area pain

ARMS AND HANDS:

- ☐ Pain in hands (LEFT/RIGHT)
- ☐ Pain in elbows (LEFT/RIGHT)
- ☐ Numbness ☐ Tingling
- ☐ Cold hands ☐ Loss of grip strength
- ☐ Swollen joints in fingers ☐ Arthritis
- ☐ Wrist pain

LOW BACK:

- ☐ Low back pain (LEFT/RIGHT)
- ☐ Upper lumbar pain ☐ Lower lumbar pain
- ☐ Tailbone pain ☐ Pain with cough/sneeze
- ☐ Pain with bowel movement ☐ Muscle spasms
- ☐ Arthritis ☐ Slipped disc
- ☐ Low back feels out of place

HIPS, LEGS AND FEET:

- ☐ pain in buttocks (LEFT/RIGHT)
- ☐ Pain in hip joint (LEFT/RIGHT)
- ☐ Pain down legs (LEFT/RIGHT)
- ☐ Knee pain (LEFT/RIGHT)
- ☐ Leg cramps ☐ Foot cramps
- ☐ Pins/needles sensation ☐ Numbness
- ☐ Swelling in Legs/Feet

CHEST:

- ☐ Chest pain ☐ Breast pain
- ☐ Shortness of breath ☐ Rib pain
- ☐ Irregular heart beat

ABDOMEN:

- ☐ Nausea ☐ Vomiting ☐ Constipation
- ☐ Diarrhea ☐ Hemorrhoids ☐ Heartburn
- ☐ Poor digestion ☐ Gallblader

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits - Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns - You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. **Please be involved in and responsible for your care.**
Inform your chiropractor immediately of any change in your condition. Do not sign this form until you meet with the chiropractor. I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____	_____	_____
Patient Name (Print)	**Signature of Patient or Legal Guardian**	**Date YYYY-MM-DD**

_____	
Treating Practitioner	**Date YYYY-MM-DD**