PATIENT HISTORY FORM

Patient: PLEASE PRINT NEATLY
First Name_______________________ M.I._____ Last_____________________________
How did you hear about us? ______________ Name of person: ____________________
Gender: M F Birthdate ____/____/____ Age: _____
Are you: ☐ Single ☐ Married ☐ Child ☐ Other
Home Address____ Apt # _________
City __________________________________ State _______ Zip _______________
Home Phone____________________ Pager/Cell Phone______________________
Work Phone_____________________________ Ext._____
E-mail Address _______________________________________
Occupation_________________________________ Duty: ☐ Regular ☐ Light
Employer Name____________________________________

Type of case:

☐ Accident ☐ Acute condition ☐ Chronic condition ☐ Wellness Care ☐ Other:
____

Brief History of Present Concern:

Please briefly explain your history of the present concern:
____
____
____
____

What activities are difficult to perform and explain?
____
____
____
____

Check all activities you are currently having difficulties with:
☐ Walking ☐ Kneeling ☐ Lifting ☐ Sitting ☐ Sports activities ☐ Loss of concentration /Scattered thought ☐ Bathing ☐ Pinching ☐ Getting Dressed/Putting on Clothes
☐ Bending over ☐ Pushing/Pulling ☐ Driving ☐ Exercising ☐ Grooming
☐ Standing in one place ☐ Squatting ☐ Twisting ☐ Pulling ☐ Eating ☐ Dressing
☐ Walking upstairs ☐ Carrying ☐ Reaching ☐ Irritable

Can you go to sleep without any problems? ☐ Yes ☐ No
Are you awaken with pain? ☐ Yes ☐ No If yes, where? ___________________________

Symptoms

Primary Complaint____

When did it start? _____________ Did it come on ☐ Gradually or ☐ Immediate

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain)
(Please circle a number) 1 2 3 4 5 6 7 8 9 10

Is this condition getting ☐ Better ☐ Same ☐ Worse

Is the pain constant? ☐ Yes ☐ No

Describe the pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing
☐ Burning ☐ Numbing ☐ Tingling ☐ Other: _________________________________

Location: ☐ Left ☐ Right ☐ Bilateral (Both)

Actions that aggravate the complaint:
☐ Bending Forward ☐ Bending Backward ☐ Bending Left ☐ Bending Right
☐ Twisting Left ☐ Twisting Right ☐ Lifting ☐ Standing ☐ Sitting ☐ Lying Down

Actions that help: ☐ Cold/Ice ☐ Heat ☐ Rest

What treatment have you already received for this condition? ☐ Medications ☐ Physical Therapy ☐ Surgery ☐ Chiropractic ☐ None ☐ Other__________________________

Extremity Concerns please explain below

Do you have any shoulder issues? ☐Yes ☐ No __________________________________
Do you have and elbow issues? ☐Yes ☐ No ____________________________________
Do you have any wrist issues? ☐Yes ☐ No _____________________________________
Do you have any hand issues? ☐Yes ☐ No _____________________________________
Do you have any hip issues? ☐Yes ☐ No ____
Do you have and knee issues? ☐Yes ☐ No _______________________________________
Do you have any ankle issues? ☐Yes ☐ No _____________________________________
Do you have any foot issues? ☐Yes ☐ No _______________________________________

Other Symptoms

☐ Headaches ☐ Loss of Smell ☐ Loss of Taste ☐ Sore Throat ☐ Loss of Balance or Dizziness ☐ Ears Ringing / Buzzing / Itching ☐ Difficulty Breathing or Asthma
☐ Stomach Upset / Acid reflux ☐ Chronic Fatigue / Low Energy
☐ Scoliosis / Scoliotic curves ☐ Chest Pain ☐ Diarrhea/Constipation (bowel issues)
☐ Hormone issues /PCOS/Uterine or Breast Fibroids/Spermatocele
☐ Irritability/Angry/Weepy Emotional
☐ Nervousness/Unmotivated ☐ Depression ☐ Poor Memory

Social History

Do You Smoke? ☐ Yes ☐ No Packs/ Day____ If no, ☐ Former Smoker ☐ Never Smoker
If former smoker, what year did you start? _______ What year did you stop? _______
Do You Drink Alcohol? ☐ Yes ☐ No Drinks/ Week______
Coffee/ Caffeine Drinks? ☐ Yes ☐ No Cups/ Day_____

What Vitamins/Nutritional Supplements or Medications do you take?
____
____

Health History

Current Medical Conditions
____
____

Please list a Description and Date (approx.)
Falls ____
Head Injuries/Concussions ____
Broken bones/Dislocations____
Surgeries____
Auto Accidents ____
Hospitalizations____
Allergies ____

Family History (Circle Which)
☐ Heart Disease: : (mother / father)
☐ Cancer: (mother / father)
☐ Liver Disease: (mother / father)
☐ Diabetes: (mother / father)
☐ Depression: (mother / father
High Cholesterol: (mother / father)
☐ High Blood Pressure: (mother / father)
☐ Drug Use: (mother / father)

Do you have any implanted medical devices in your body including screws and pins? If yes, where and what are they? ____
____
Have you had any fusions? ☐ Yes ☐ No If yes, where?__________________________

Any hormone replacement therapy? ☐ Yes ☐ No
Do you have any implants? ☐ Yes ☐ No

Women

Are you Pregnant? ☐ Yes ☐ No If yes, how many months? _____
Taking Birth Control or IUD? ☐ Yes ☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature_______________________________________Date_____________

PAIN CHART FORM

Mark the areas on this drawing where you feel the described sensations. Use appropriate symbols & include **all** affected areas. Also please rate the severity of your pain next to each area. (1, mild pain or discomfort, to 10, severe pain)

Numbness	Pins & Needles	Burning	Aching	Stabbing
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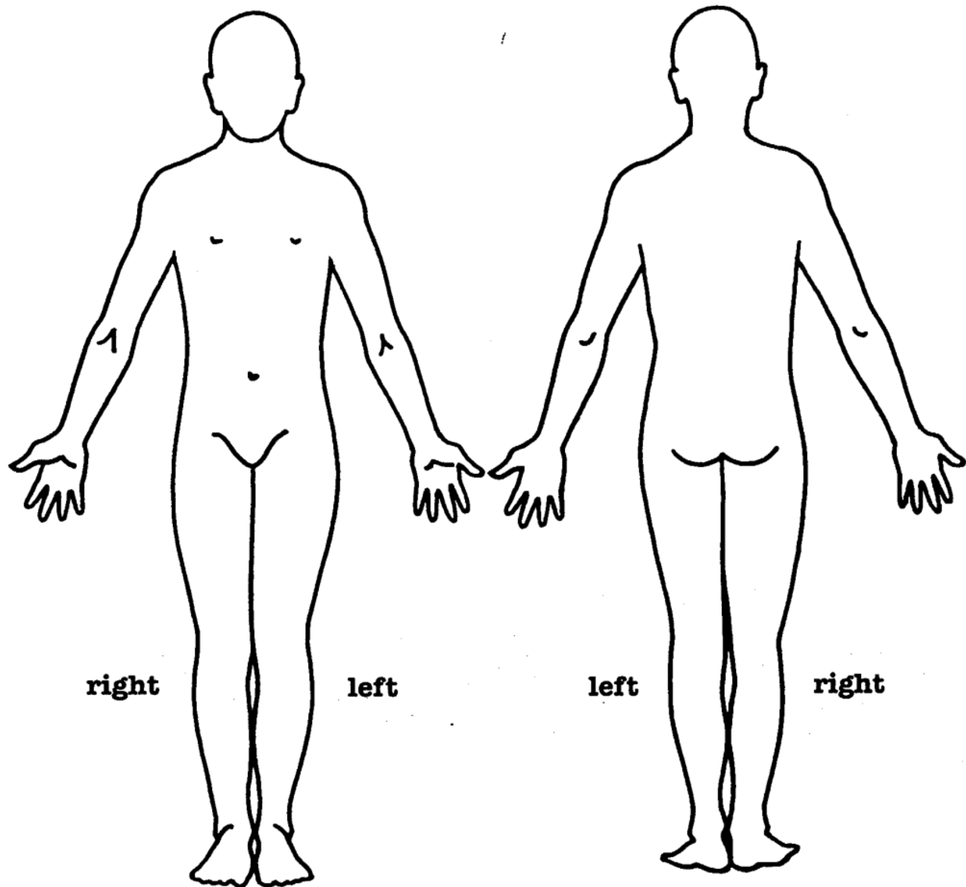

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes an alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ___________________________________ (Print Name) have read and fully understand the above statements. All 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.
Signature: ____ Date: _________________

Consent to Evaluate and Adjust a Minor Child

I, _________________________________being the parent or legal guardian of _____________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
Parent Signature: ______________________________________ Date: ______________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

City ___________________________Zip _______________________

Social Security Number _______-_______-_______

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ____ Date: _________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________________________

Relationship to Patient: _______________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:____ Date:__________

Informed Consent for the Chiropractic Patient: To the Patient:

Please read document and sign. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. He or she may use her hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Analysis/Examination/Treatment: As part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, Essential Oil or massage cream application, electric muscle therapy, and traction therapy.
The risks inherent in chiropractic adjustment: As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's obvious attention, it is your responsibility to inform the doctor.
Authorization for the release of patient information: I hereby authorize Skypoint Chiropractic to provide other health care providers with information regarding my healthcare as deemed appropriate. I give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care. Do not sign until you have read and understand the above. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to understand the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified otherwise.

Patient's Signature:____ Date:_____________

Signature of parent/guardian (if minor)________________________Date:_____________