SPINAL PERCEPTIONS CHIROPRACTIC AND WELLNESS HEALTH HISTORY FORM

Today's Date_____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home or Cell Phone (___) _____ Secondary Phone (___)_____

E-mail address_____ Social Security Number_____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner _____

Emergency Contact Name and Number _____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Spinal Perceptions Chiropractic and Wellness can address for you?

What date did these problems begin? _____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

Date of last visit: _____ Reason for Visit:_____

Name of Primary Care Doctor:_____ Date of Last Visit:_____

Reason for Visit:_____

FOR WOMEN

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: _____Date:_____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

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PHYSICAL STRESS:

Please list the major traumas that you remember from your childhood up to the present.

Major accident or falls:_____

Major Surgery/Operations: __ Appenedctomy __Tonsillectomy __Gall Bladder __Hernia

__Back Surgery __Broken Bones __Other:_____

Hospitlizations (Other than Above):_____

Check any of the following you have had in the past 6 months:

Musculo-Skeletal Code

- ❒ Low Back Pain
- ❒ Pain Between Shoulders
- ❒ Neck Pain
- ❒ Arm Pain
- ❒ Joint Pain/Stiffness
- ❒ Walking Problems
- ❒ Difficulty Chewing/Clicking Jaw
- ❒ General Stiffness

Nervous System Code

- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusions/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremeties

Gastro-Interstinal Code

- ❒ Poor/Excessive Appetite
- ❒ Excessive Thirst
- ❒ Frequent Nausea
- ❒ Vomiting
- ❒ Diaarrhea
- ❒ Constipation
- ❒ Hemorrhoids
- ❒ Liver Problems
- ❒ Gall Bladder Problems
- ❒ Weight Trouble
- ❒ Abdominal Cramps
- ❒ Gas/Bloating After Meals
- ❒ Heartburn
- ❒ Black/Bloody Stool
- ❒ Colitis

Genito Urinary Code

- ❒ Bladder Trouble
- ❒ Painful/Excessive Urination
- ❒ Discolored Urine

- ❒ Cardiovascular/Respiratory
- ❒ Chest Pain
- ❒ Short Breath
- ❒ Blood Pressure Problems
- ❒ Irregular Heartbeat
- ❒ Heart Problems
- ❒ Lung Problems/Congestion
- ❒ Varicose Veins
- ❒ Ankle Swelling
- ❒ Stroke

Eyes/Ears/Noes/Throat

- ❒ Vision problems
- ❒ Dental Problems
- ❒ Sore Throat
- ❒ Ear Aches
- ❒ Hearing Difficulty
- ❒ Stuffed Nose

Male/Female

- ❒ Menstrual Irregularity
- ❒ Menstrual Cramps
- ❒ Vaginal Pain/Infection
- ❒ Breast Pain/Lumps
- ❒ Prostate/Sexual Dysfunction

General

- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches
- ❑ Other_____
  _____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

EMOTIONAL STRESS:

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	__	Loss of loved one	__	Abuse	__
Work or School	__	Divorce/separation	__	Financial	__
Lifestyle change	__	Illness	__		

CHEMICAL STRESS:

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals	❑ Second hand smoke	❑ Drug therapy
❑ Radiation	❑ Chemotherapy	❑ Other

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall “quality of life”?	❑ Good	❑ Fair	❑ Poor

Do you exercise regularly? If yes, how often? _____

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

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

❒ OTHER_____

PLEASE READ AND SIGN

1. I have been informed that a copy of Spinal Perceptions Chiropractic and Wellness *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the office. _____ (initial)
2. I consent to receive communication from Spinal Perceptions Chiropractic via phone or voicemail regarding my care. If I should withdraw my consent, I will notify the office in writing. _____ (initial)
3. Once per month, we host a free wellness seminar (Shop with the Doc, Recipe Day, Mommy and Me Class etc) and publish a newsletter. By initialing below, you consent to recieving a monthly newsletter notification with the free seminar information. You may opt out at any time. _____ (initial)
4. I clearly understand and agree that all services rendered 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 care is suspended or terminated, any fees for professional services rendered will become immediately due and payable. _____ (initial)
5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered. _____ (initial)

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Marquetta Giles DC permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____ Date: _____

Signature: _____

Signature of Parent (for minor):_____ Date: _____

Thank you for choosing Spinal Perceptions Chiropractic and Wellness.

We look forward to helping you.