

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name: _____ **Date:** ____/____/____ **Sex:** Female Male
 First MI Last

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Birth Date: ____/____/____ **Height:** _____ **Weight:** _____ **e-mail address:** _____

Your Employer: _____ **Occupation:** _____

Spouse/ Parent's Name: _____ **Status:** Minor Married Single Other

Names and Ages of Children: _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency: _____ **Phone:** _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Gonstead Family Chiropractic can address for you?

- Wellness Care Neck Pain Mid Back Pain Arm Pain Numbness in Fingers Pins and Needles in Arms
 Headaches Neck Stiffness Low Back Pain Leg Pain Numbness in Toes Pins and Needles in Legs
 Other: _____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

Have you ever been diagnosed with a Subluxation? No Yes, When? _____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Yes No Name of D.C. _____

How long under care? _____ Days _____ Years Date of last visit: _____

Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Medical Physician | <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: _____

Patient Signature: _____ **Today's Date:** ____/____/____

FOR WOMEN

Are you pregnant? Yes No 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: _____

Health, Wellness & Chiropractic Care

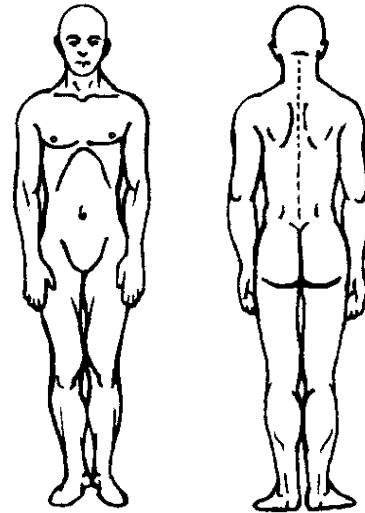
PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT BELOW: (reason for seeking treatment)

1) _____ 2) _____ 3) _____ 4) _____
0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE
BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other	= ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Please describe any other activities that are restricted due to this injury? _____

When did you first notice these symptoms? _____ Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you had an injury or fall? No Yes, Describe _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

I am currently taking the following medications/supplements for the following reasons: None

Surgical History: _____ None

Do you currently have or have you previously had any of the following symptoms:

- | | | | | | |
|--------------------------------------|---------------------------------------|--|---|---------------------------------------|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary Problems |

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 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)

- | | | |
|---|--|---|
| <input type="checkbox"/> Relief of a symptom only | <input type="checkbox"/> Relief and Prevention of a symptom or problem | <input type="checkbox"/> Healthier spine and nerve system |
| <input type="checkbox"/> Optimal health on all levels | <input type="checkbox"/> OTHER _____ | |

Health, Wellness & Chiropractic Care

The primary system in the body which coordinates health is the NERVE SYSTEM.

The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION and results in nerve malfunction .

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to, how they may relate to your present spinal, nerve and health status and whether they have caused Vertebral Subluxations.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

- Home Natural Hospital Caesarian section Forceps
Breech Cord around neck Prolonged labor Drug induced labor Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (Check all that apply)

- Automobile Motorcycle Bicycle Sports Playground Abuse

If yes, state type of injury and date: _____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? Yes No - If yes, list body parts: _____

Have you ever been hospitalized or had surgery? Yes No

If yes, state reason and dates: _____

How often do you get outside activity/exercise? What types? _____

Do you sit more than 3 hours a day? Yes No - If yes, how many? _____ hours/day Hours of TV a day? _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Loved One | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Work or School | <input type="checkbox"/> Yes <input type="checkbox"/> No | Divorce/Separation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Financial | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lifestyle Change | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parents Divorce | <input type="checkbox"/> Yes <input type="checkbox"/> No | Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |

On a scale of zero to ten, rate the amount of STRESS in your LIFE.

0 1 2 3 4 5 6 7 8 9 10
None to Little STRESSED to MAX

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

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.

Were you vaccinated? Yes No If yes, did you have a reaction? Yes No Unsure

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: _____

If yes, please list: _____

Do you have allergies or sensitivities to any foods? Yes No If yes, please list: _____

Do you presently consume any of the following?

- Coffee/Caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs Sugar

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

Thank you for choosing Gonstead Family Chiropractic. We look forward to serving you.