NEW PATIENT/CONDITION FORM
PERFECT HEALTH CHIROPRACTIC

Name: _____ Date: _____

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

Age: _____ Sex: _____ Birth Date: _____ Marital Status: M S W D

Phone: _____ Social Security: _____ Spouse's Name: _____

Occupation: _____ Employer: _____

Work Phone: _____ Work Address: _____

Referred By: _____ Number of Children: _____

E-Mail Address: _____

What is/are your major complaints? _____

Is this a condition due to an? Auto Accident ____ Work Injury ____

(Check One) Unknown Illness ____ Illness ____ Other Injury ____

Are the symptoms: Improving ____ Getting Worse ____ Same ____

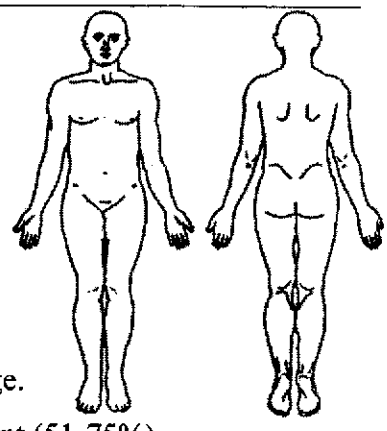
Come and Go ____ When did the symptoms appear? _____

Which phrases best describe *changes* in your symptoms during the day?

____ It is worse in the morning. ____ It is worse in the afternoon.

____ It is worse at night. ____ It changes with the weather. ____ It doesn't change.

Mark an "X" where your pain is located.



What describes the frequency? ____ Constant (76-100% of the time) ____Frequent (51-75%)

____ Intermittent (26-50% of the time) ____ Occasional (0-25%)

What helps relieve your condition? Ice Heat Medication Nothing Helps Other _____

What activities are limited by your symptoms?

☐ Bending	☐ Driving	☐ Pulling	☐ Sleeping	☐ Urination
☐ Bowel Movement	☐ Getting Up	☐ Pushing	☐ Sneezing	☐ Walking
☐ Coughing	☐ Lifting	☐ Reading	☐ Standing	☐ Working
☐ Daily Routine	☐ Lying Down	☐ Sitting	☐ Turning My Head	☐ Other _____

Have you had these symptoms before? (Y / N) If so, when? _____

Have you seen anyone else for this condition? _____ Dr.'s Name: _____

Date Consulted: _____ Diagnosis: _____

Date of Last:		Habits:		Have you ever:	
	Physical Exam		Alcohol		Been knocked unconscious?
	Spinal X-ray		Coffee		Used a crutch or other support?
	MRI		Tobacco		Been treated for a spine or nerve disorder?
	Dental X-ray		Drugs		Had a fractured bone?
	CT Scan		Coke or Pepsi		Been hospitalized for other than surgery?
	Other scans or x-rays		Other		Ever had a surgery?

Please list any drugs now taken, allergies, and past surgeries: _____

_____

Check the Following Conditions You Have or Had!
Circle items that are common to other family members.

Have	Had		Have	Had		Have	Had	
		Alcoholism			Emphysema			Multiple Sclerosis
		Anemia			Goiter			Polio
		Appendicitis			Gout			Rheumatic Fever
		Cancer			Heart Disease			Stroke
		Diabetes			Miscarriage			Tuberculosis
		Eczema			Foot Problems			Ulcers

Please check the appropriate box for any of the following symptoms which you NOW have OR have HAD.

This is a confidential report.

Often	Rarely		Often	Rarely		Often	Rarely		Often	Rarely	
GENERAL					Knees			Sinus Infections	GENITO-URINARY		
		Allergy (list below)			Feet	CARDIO-VASCULAR					Bed-Wetting
		Convulsions	GASTRO-INTESTINAL					Hardening of Arteries			Blood in Urine
		Dizziness or Fainting			Colon Trouble			High Blood Pressure			Frequent Urination
		Headaches			Constipation			Low Blood Pressure			Incontinence
		Neuralgia			Diarrhea			Pain Over Heart			Kidney Infection/Stones
		Numbness			Difficult Digestion			Poor Circulation			Painful Urination
MUSCLE & JOINT					Abdomen Distended			Rapid Heart Beat			Prostate Trouble
		Arthritis			Gall Bladder Trouble			Slow Heart Beat			Pus in Urine
		Bursitis			Hemorrhoids			Swelling of Ankles	FOR WOMEN ONLY		
		Foot Trouble			Liver Trouble	RESPIRATORY					Congested Breasts
		Low Back Pain			Pain Over Stomach			Chest Pain			Cramps or Backache
		Neck Pain/Stiffness	EYES, EARS & NOSE					Chronic Cough			Excessive Menstrual Flow
		Between Shoulders			Asthma			Difficult Breathing			Hot Flashes
		Sciatica			Colds			Spitting Up Blood			Irregular Cycle
		Swollen Joints, Pain			Deafness			Spitting Up Phlegm			Lumps in Breasts
		Shoulders			Earache			Wheezing			Menopausal Symptoms
		Arms			Ear Discharge	SKIN					Painful Memstruation
		Elbows			Ear Noises			Bruise Easily			Pregnant (Y / N)
		Hands			Eye Pain			Dryness	Last Period:		
		Hips			Nasal Obstruction			Skin Eruptions (Rash)			
		Legs			Nose Bleeds			Varicose Veins			

Have you ever been in an auto accident? ( ) Yes ( ) No When? _____

Have you been treated by a physician for any health condition in the past year? ( ) Yes ( ) No

By whom? _____ Address: _____

Describe condition: _____

Are you allergic to any medication? ( ) Yes ( ) No What kind? _____

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely. Your signature below also signifies that you are consenting to Chiropractic care that has been recommended at this clinic and that you are aware of the risks involved with such care.

Patient Signature: _____ Date: _____

Signature of Legal Guardian (if applicable): _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: