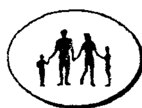

WAKARUSA FAMILY CHIROPRACTIC

117 S. Elkhart St.•P.O. Box 509•Wakarusa, IN 46573 Phone/Fax: 574-862-1409

Your Full Name: ______________________________________ Today's Date: ____

Address: ____ Home #: _____________________ Cell #: _____________________

____ Work #: ______________________ E-mail:_____________________

Birth Date: _______________ Age: ____________SS#: ______________________ Do you have Medicare: Yes ______ No ______

Spouse's Name: ______________________________________ Children (ages): ____

Your Employer: ___________________________ Occupation: _________________________ Years on Job: ____________________

Previous Chiropractor: ____ Date of last visit: ________________________

What type of care did you receive? (Relief / Correction / Wellness) Did you follow their recommendations? ___ Yes ___ No
If not , why not? ______________________________________

Reason for changing chiropractors:____

Reason for contacting our office: _____ Relief of Symptoms _____ Correction of Problem _____Wellness care for optimizing your personal or family's health

Present MD: _______________________ City: ___________________ Referred to our office by: ___________________________

Contact Name in case of an Emergency: _________________________________ Phone #: ____________________________________

****

Adult Consultation History

1. Your Primary Health Concern(s):____
2. Other concerns (in order of importance):____
3. How long have you dealt with this issue(s)? ____
4. How did it start? ____
5. What have you tried to do to address this issue(s) that DID NOT work? ____

   ____
6. Has anything given you temporary benefit? ____
7. What is the pattern of this difficulty(ies)? ______ Constant, ______ Intermittent, ______Occasional, ______ Cyclic
8. What makes it worse? ____
9. At its worst, how does it make you feel? ____
10. How does this issue(s) interfere with the following areas? Work: ____

    Family:_____________________________ Hobbies:_________________________________ Life:______________________
11. Have you become discouraged about handling this challenge? ____
12. When was the last time you felt your best? (How long ago?) ____
13. What are your health goals and expectations? ____

    ____

14. On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us find a solution to this health concern(s): ____

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential

15. Have you been involved in any auto accidents, experienced significant injuries, or serious illnesses?________________________

    If yes, give details: ____

    ____

16. Have you had any surgeries? ______ If yes, when and why:____

    ____

17. Have you ever fractured any bone(s)? Yes ____ No____ If yes, when and what? ____

    ____

18. Are you on any type of medication (even non prescription)? ______ Please list all and reason:______________________________

    ____

19. How stressful is your life? (rate on a scale of 1 to 10, with 10 being the highest) Occupation __________ Personal ___________

20. What do you feel is your primary stress? ____

21. Do you have any children? ________ Do they have any health issues that you are aware of? ______________________________

    ____

22. Is there any other information you would like us to know? ____

    ____

Signature: ____ Date: ____

For Women Only

1. Date of your last menstrual period: ___________
   ____
2. Are you using any means of contraception: _____
   ____
3. Do you experience severe cramping with your menstrual period? _________________________
4. Do you suffer from PMS?___________________
   ____

***IN CASE OF EMERGENCY*:**
(Name of a relative or close friend not living in your home):

NAME:_____________________________________
ADDRESS:__________________________________
PHONE:____________________________________

Lifestyle Questions

1. What sports / recreational activities / hobbies do you participate in?
   ____
   ____
2. Rate both the quality and quantity of your sleep (rate on a scale of 1 to 10) ____
3. Do you wear arch supports or shoe lift? _______________________
   ____
4. List any vitamins or supplements you take_____________________
   ____
5. Are you on a special diet? __________________________________
   ____
6. Do you use: ___ Tobacco ___Alcohol ___Caffeine ___Drugs
   Please list how much and how long for each item marked above
   ____
   ____
   ____

Confidential Patient Case History

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your situation will respond satisfactorily, we will not accept your case. THANK YOU.

Name:____Date:______________________

Please check the appropriate box for any of the following symptoms that you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O=OCCASIONAL
F=FREQUENT
C= CONSTANT

O	F	C	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Vertigo / Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
☐	☐	☐	Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joint
☐	☐	☐	TMJ

O	F	C	GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive / poor appetite
☐	☐	☐	Excessive thirst
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental problems
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Shortness of breath
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anemia	☐ Diptheria	☐ Heart disease	☐ Mumps	☐ Thyroid
☐ Arteriosclerosis	☐ Eczema	☐ HIV positive	☐ Pleurisy	☐ Tuberculosis
☐ Cancer	☐ Emphysema	☐ Influenza	☐ Pneumonia	☐ Typhoid fever
☐ Chorea	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Ulcers
☐ Cold sores	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Venereal disease
☐ Concussion	☐ Goiter	☐ Miscarriage	☐ Scarlet fever	☐ Whooping cough

FINANCIAL POLICY

We encourage and welcome frank discussion of fees and services prior to the beginning of care in order to avoid misunderstandings.

It is important for you to be informed that if you are covered by health insurance, our professional services are charged to you, not the insurance company. Insurance policies are an arrangement between you, the policyholder, and the carrier. Our services our offered on the basis that full charges will be paid by you.

You will receive a receipt after each office visit, which will have all the information the insurance company requires for reimbursement. When submitting your insurance claim form, include these receipts after cutting off the bottom portion on the dotted line.

Please keep our office informed on any special circumstances or requirements.

Most insurance policies provide limited coverage. We encourage you to be fully aware of the provisions of your policy.

This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed when and if a plan of corrective care is recommended.

If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

____

Signature Date

DOCTOR-PATIENT RELATIONSHIP
AND
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity t use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, many conditions, which do not respond to chiropractic care, may come under the control or be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems, however both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nerve system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures that he/she is suffering from: pathological conditions (latent of otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of understanding and consent for care.

I have read and understand the foregoing. I hereby give my consent for the doctor to render chiropractic care for me.

______________________________________ ________________________

Patient's Signature Date