



**WELCOME TO OUR OFFICE!**  
**Patient History**  
 (All information is confidential)

Please allow us to help you by completing the following information. Please print neatly. And please sign and date each page at the bottom (in the designated areas).

Thank you!

**ABOUT YOU**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_ Social Security Number: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Drivers License #: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Who May We Thank For Referring You? \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
 Cell phone #: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Marital Status: Married / Divorced / Single / Widowed  
 Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
 How many children do you have? \_\_\_\_\_  
 In event of emergency who should we contact? \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_  
 Patient's Relationship To Insured: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
 Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**WHAT BRINGS YOU TO OUR OFFICE?**

Describe your symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 Date when symptoms first appeared: \_\_\_\_\_  
 Did it begin: (circle) *Gradually Suddenly Progressed over time*  
 Was this problem due to an auto accident or work related injury? (circle) *Yes / No*  
 What makes the symptoms worse? \_\_\_\_\_  
 What relieves the symptoms? \_\_\_\_\_  
 Quality of pain: (circle) *Dull/Achy Sharp/Stabbing Burning Throbbing Electrical*  
 Does the pain radiate into your: (circle) *Arm Leg Head Does Not Radiate*  
 Do you experience numbness or tingling? (circle) *Yes / No*  
 What percent of the time do you experience these symptoms? *100% 75% 50% 25% 10%*  
 What have you already tried to resolve this problem: (check all that apply)  
 Over The Counter Drugs     Prescription Strength Drugs     Physical Therapy     Surgery  
 Chiropractic     Massage Therapy     Acupuncture     Nutritional Supplements

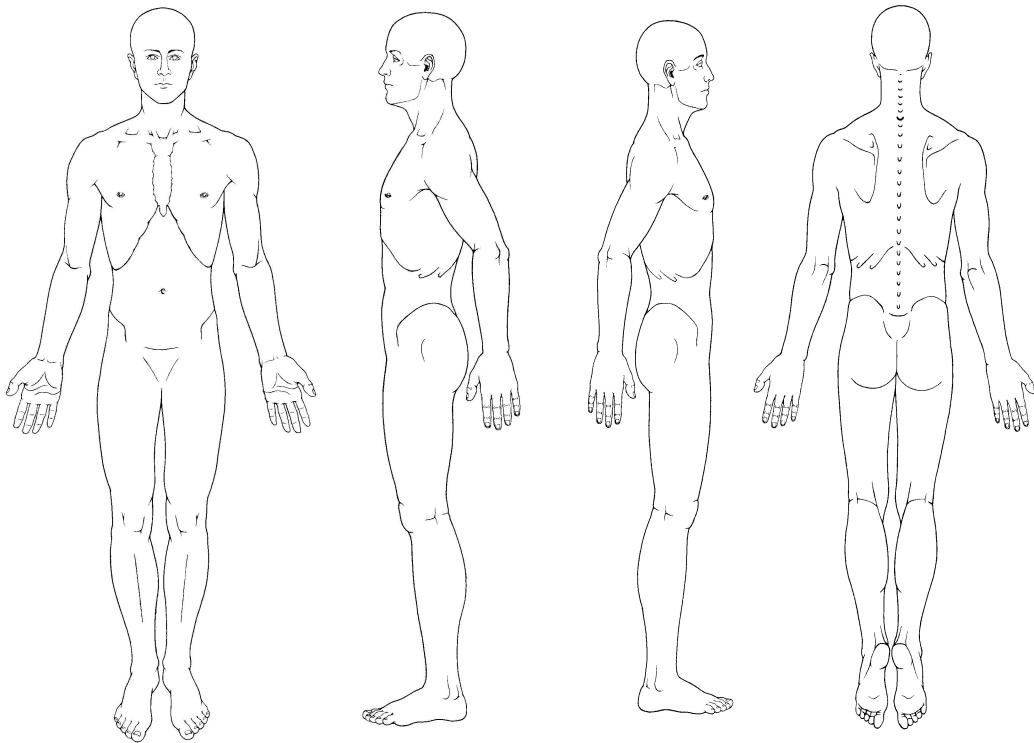
PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## LOCATION OF SYMPTOMS

Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain).

Pain = **PPP**  
 Numbness = **NNN**  
 Burning = **BBB**

Tingling = **TTT**  
 Cramping = **CCC**  
 Radiating Pain = **~~~~~**



## SEVERITY OF PAIN & SYMPTOMS

Please mark an "X" on the lines below to indicate the intensity of your pain:

1. Right now:            No Pain \_\_\_\_\_ Worst Possible Pain
2. Average:             No Pain \_\_\_\_\_ Worst Possible Pain
3. At Worst:            No Pain \_\_\_\_\_ Worst Possible Pain

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL HISTORY**

**Check any of the symptoms you have noticed** ( = previously,  = now)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Low Back Pain or Stiffness     | <input type="checkbox"/> <input type="checkbox"/> Auto Accidents          | <input type="checkbox"/> <input type="checkbox"/> Vision / Eye Problems   | <input type="checkbox"/> <input type="checkbox"/> Sports Injuries         |
| <input type="checkbox"/> <input type="checkbox"/> Mid Back Pain or Stiffness     | <input type="checkbox"/> <input type="checkbox"/> H / L Blood Pressure    | <input type="checkbox"/> <input type="checkbox"/> Ear Problems            | <input type="checkbox"/> <input type="checkbox"/> Frequent Colds / Flus   |
| <input type="checkbox"/> <input type="checkbox"/> Upper Back Pain or Stiffness   | <input type="checkbox"/> <input type="checkbox"/> Work Injuries           | <input type="checkbox"/> <input type="checkbox"/> Nose / Sinus Problems   | <input type="checkbox"/> <input type="checkbox"/> Prostate Problems       |
| <input type="checkbox"/> <input type="checkbox"/> Neck Pain / Stiffness          | <input type="checkbox"/> <input type="checkbox"/> Other Accidents / Falls | <input type="checkbox"/> <input type="checkbox"/> Throat Problems         | <input type="checkbox"/> <input type="checkbox"/> Female Problems / PMS   |
| <input type="checkbox"/> <input type="checkbox"/> Headaches                      | <input type="checkbox"/> <input type="checkbox"/> Fractured Bones         | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> <input type="checkbox"/> Incontinence            |
| <input type="checkbox"/> <input type="checkbox"/> Migraine                       | <input type="checkbox"/> <input type="checkbox"/> Sore Achy Muscles       | <input type="checkbox"/> <input type="checkbox"/> Allergies               | <input type="checkbox"/> <input type="checkbox"/> Impotence               |
| <input type="checkbox"/> <input type="checkbox"/> Pain radiating down arm(s)     | <input type="checkbox"/> <input type="checkbox"/> Tiredness / Fatigue     | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems    | <input type="checkbox"/> <input type="checkbox"/> Pain w/ coughing        |
| <input type="checkbox"/> <input type="checkbox"/> Numbness / Tingling Arm(s)     | <input type="checkbox"/> <input type="checkbox"/> Dizziness               | <input type="checkbox"/> <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> <input type="checkbox"/> Pain w/ sneezing        |
| <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome         | <input type="checkbox"/> <input type="checkbox"/> Fainting                | <input type="checkbox"/> <input type="checkbox"/> Circulation Problems    | <input type="checkbox"/> <input type="checkbox"/> Pain at stools          |
| <input type="checkbox"/> <input type="checkbox"/> Shoulder Pain / Stiffness      | <input type="checkbox"/> <input type="checkbox"/> Stress                  | <input type="checkbox"/> <input type="checkbox"/> Digestion Problems      | <input type="checkbox"/> <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> <input type="checkbox"/> Elbow Pain / Stiffness         | <input type="checkbox"/> <input type="checkbox"/> Tension                 | <input type="checkbox"/> <input type="checkbox"/> Intestine Problems      | <input type="checkbox"/> <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> <input type="checkbox"/> Wrist / Hand Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Nervousness             | <input type="checkbox"/> <input type="checkbox"/> Colorectal Problems     | <input type="checkbox"/> <input type="checkbox"/> Restricts Exercise      |
| <input type="checkbox"/> <input type="checkbox"/> Hip Pain or Stiffness          | <input type="checkbox"/> <input type="checkbox"/> Irritability            | <input type="checkbox"/> <input type="checkbox"/> Liver / Gall Bladder    | <input type="checkbox"/> <input type="checkbox"/> Unable to Work          |
| <input type="checkbox"/> <input type="checkbox"/> Pain radiating down leg(s)     | <input type="checkbox"/> <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> <input type="checkbox"/> Poor Diet               |
| <input type="checkbox"/> <input type="checkbox"/> Knee Pain or Stiffness         | <input type="checkbox"/> <input type="checkbox"/> Concentration           | <input type="checkbox"/> <input type="checkbox"/> Diabetes / Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Inadequate Water Intake |
| <input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain or Stiffness   | <input type="checkbox"/> <input type="checkbox"/> Mood Disorders          | <input type="checkbox"/> <input type="checkbox"/> Bladder Problems        | <input type="checkbox"/> <input type="checkbox"/> Inadequate Exercise     |
| <input type="checkbox"/> <input type="checkbox"/> Trouble Walking                | <input type="checkbox"/> <input type="checkbox"/> Depression              | <input type="checkbox"/> <input type="checkbox"/> Skin Problems           | <input type="checkbox"/> <input type="checkbox"/> No Energy               |
| <input type="checkbox"/> <input type="checkbox"/> Restricts Daily Activity       | <input type="checkbox"/> <input type="checkbox"/> Memory Loss             | <input type="checkbox"/> <input type="checkbox"/> Excessive Sweating      | <input type="checkbox"/> <input type="checkbox"/> Other _____             |

Please list all medications you're taking: \_\_\_\_\_

Please list all hospitalizations and surgeries (with dates): \_\_\_\_\_

Please list all traumas (sports injuries, automobile accidents, slips & falls): \_\_\_\_\_

Please list all known allergies: \_\_\_\_\_

Do you have any implants, surgical hardware, pacemakers or metallic sutures?  Yes  No  
 [Females Only]

Are you pregnant?  Yes  No Date of the start of your last menstrual cycle: \_\_\_\_\_

Have you ever been diagnosed with:  Cancer  Diabetes  Cardiovascular Disease

Have you experienced any unintentional weight loss?  Yes  No

Please list all dietary supplements you're taking: \_\_\_\_\_

How many glasses of water (per day) do you drink? \_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_

How many hours of sleep do you get per day? \_\_\_\_\_

How would you rate your diet? (circle one) Poor ← 1 2 3 4 5 → Excellent

How would you rate your overall energy? (circle one) Poor ← 1 2 3 4 5 → Excellent

How would you rate your stress levels? (circle one) Low ← 1 2 3 4 5 → High

On a scale of 1 through 10 (1 being the least, 10 being the most), how committed are you in wanting to get this problem handled once and for all? (circle)

1      2      3      4      5      6      7      8      9      10

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# Authorization For The Use Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

**Indiana Spine Center Family Chiropractic and/or David T. Young, D.C.**

3. I authorize the following persons (or class of persons) to receive my protected health information:

**Indiana Spine Center Family Chiropractic and/or David T. Young, D.C**

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).
7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Indiana Spine Center Family Chiropractic, nor will it affect my eligibility for benefits.

I certified that I have received a copy of the authorization:

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_