CONFIDENTIAL HEALTH HISTORY

Name: _____ **Address:** _____

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

Home Phone: _____ **Birth Date:** _____ **Age:** _____ **Sex: M F**

Social Security# _____-_____-_____ **Driver's License #:** _____**State:**_____

Mobile # _____ **E-mail:**_____ **Marital Status: S M D W**

Occupation: _____ **Name of Spouse:** _____

Names and Ages of Children: _____

Case of An Emergency Contact: _____ **Phone #**_____

Who Referred You to Our Office: _____

Would you like "APPOINTMENT REMINDERS" For Scheduled Appointments: Yes - ☐ No - ☐

DESCRIBE YOUR COMPLAINTS

Describe Your Chief Complaint: _____

_____

When Did This Condition Begin? _____

How Did This Condition Begin? _____

What Makes Your Complaint Worse?_____

What Have You Done To Help Your Complaint? _____

_____

Has This Condition Ever Occurred Before? NO , YES - When_____ **How many Other times?**_____

Other Doctors You Have Seen For This Condition:_____

*** What Other Complaints Do You Suffer From?** _____

_____

Height: _____ **Weight:** _____ **High Blood Pressure?** _____ **Diabetic?** _____

YOUR HEALTH CARE GOALS

What Are Your Specific Goals For Your Health Consultation Today? _____

Would You Like Us To Address Your Nutritional Habits And Would Like Help Improving them? ☐ YES ☐ NO

Would You Like Us To Review Your Nutritional Supplements? ☐ YES ☐ NO Review Past Lab Tests? ☐ YES ☐ NO

Are You Now On A Nutritional Treatment Plan From Another Physician? ☐ YES ? _____ **For:** _____

For _____ **☐ NO, Just On Own**

Do You Feel Stress Has An Affect On Your Health Issue? ☐ YES ☐ NO Do You Have Restful Sleep? ☐ YES ☐ NO

Do You Exercise? ☐ YES ☐ DAILY ☐ 3 x's/Week ☐ NO Do You Have An IN-ACTIVE Lifestyle? ☐ YES ☐ NO

Are You Willing To Make Changes In Your Life To Improve Your Health? ☐ YES ☐ NO ☐ KINDA—50/50 But being Honest

Rate Your Commitment To Good Health? LOW ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 HIGHEST

OTHER Info: _____

SOCIAL HISTORY

Do You Drink Alcohol? NO , YES - How Much Daily:_____ Total Weekly:_____

Do You Use Tobacco Products (Circle)? Cigarettes - Chewing NO , YES - How Much Daily: _____

Recreational Drug Use?_____

MEDICAL HISTORY

Date of Last Physical: _____ Dr.'s Name: _____

Please List <u>All</u>:
Major Accidents And Falls You Have Had :_____

_____

Hospitalizations: Surgeries_____

Do you have any <u>CHRONIC</u> Conditions *(Autoimmune, Pain, Cancer, Arthritis, Hypo-Thyroid)*: YES: _____ NO

Previous Chiropractic Care: [ ] None, (Date & Doctor)_____

MEDICATIONS / VITAMINS

List Medications / Vitamins And What Condition You Are Taking Them For:

Medication / Vitamin:	**Condition:**
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATION: (list All) _____

FAMILY HEALTH HISTORY

List Any And All Conditions That Your Family Members Have Or Have Had (Cancer, Diabetes, Heart Conditions, Etc) :

MOTHER (Age:_____) _____

FATHER (Age:_____) _____

SIBLING (Age:_____) _____

SIBLING (Age:_____) _____

REVIEW OF SYMPTOMS

Circle ALL You Have:

HEADACHES	**BUMPS ON HEAD**	**EAR PAIN**	**RINGING IN EARS**	**HEARING LOSS**	**LUMPS ON NECK**
EYE PAIN	**VISUAL PROBLEMS**	**NOSE PAIN**	**SINUS PAIN**	**ALLERGIES**	**COLD SORES**
TEETH PAIN	**MOUTH PAIN**	**HARD TO SWALLOW**		**BREATHING PROBLEMS**	**COUGHING**
CHEST PAIN	**CHEST PRESSURE**	**LUMPS IN BREASTS**		**LUMPS IN ARM PITS**	**HEART POUNDING**
BURPING	**BLOATING**	**STOMACH PAINS**		**CONSTIPATION**	**DIARRHEA**
HEMORRHOIDS	**PAINFUL URINATION**	**LUMPS IN GROIN AREA**		**LUMPS ON GENITALS**	**GENITAL HERPES**
SWELLING IN ARMS	**SWELLING OF LEGS**	**SORES ON FEET**		**IN-GROWN NAILS**	**NUMB FEET / HANDS**

CONSENT TO EXAM / TREATMENT / HIPAA POLICY

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The practice of chiropractic involves the doctor to conduct a physical exam and to physically touch the body. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Although doctors of Chiropractic are experts in chiropractic diagnosis, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases unknown underlying physical defects, deformities or pathologies may increase the patient susceptible to injury. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defect, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. Some of the risk of treatment could result in bruising of the skin, pain in the muscles and joints, strains/sprains of the joints, joint dislocation, bone fractures, disc injuries and in rare circumstance neurological injuries and/or strokes.

We will do everything possible to reduce the chances of these risks but your permission is necessary to begin care.

I hereby request and consent to have Dr. Dearmont, DC perform a physical examination and perform treatment which may include spinal and soft tissue manipulations to help improve my complaints. I understand and am informed that, as in the practice of medicine and Chiropractic, there are some risks to all treatments. I do not expect the doctor(s) to be able to anticipate all these risks and complications, and I will rely on the doctor (s) to exercise their professional judgment during the course of my care concerning which treatment(s) are in my best interest, based upon the facts as they known.

***X*_____ *DATE:* _____**

Patient's Signature to Consent to Care:

Acknowledgement of Receipt of Notice of Privacy Practices: CHIROPRACTIC HEALTHCARE CENTER USES PERSONAL INFORMATION ONLY AS RELATED TO PROVIDING CARE AND BILLING PURPOSES IN ACCORDANCE WITH STATE AND FEDERAL PRIVACY GUIDELINES. WE DO NOT SHARE YOUR INFORMATION BEYOND WHAT IS REQUIRED FOR THESE PURPOSES.

I acknowledge that I may request a copy of the Notice of Privacy Practices or I have declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

***X*_____ *DATE:* _____**

Patient's Signature to HIPAA Policy: