East Side Chiorpractic Office
Patient History Form

Last Name ______________ First Name ______________ Date __________
Social Security # ______________ Birth Date ______________ Age ______
Address ______________ City ______________ State ______ Zip ______
Home Phone ______________ Work Phone ______________ Cell Phone ______________
Email address ______________ Primary Care Physician ______________
Employer ______________ Occupation ______________ Years ______
Marital Status ______________ No. of Children ______ Spouse's Name ______________
Spouse SS# ______________ Spouse Employer ______________
How did you hear about our clinic? ______________

Section A *Describe your complaints in order of severity (1st complaint, 2nd complaint, etc...)*

1st Complaint ______________ Date Started ______________
What is the history of this injury or symptom?
____
____
____
____
What makes your problem worse? ______________
What makes your problem better? ______________
How would you describe your pain? ______________
What is the location or radiation of your pain? ______________
How bad is your pain on a scale of 0 to 10? *(0=no pain and 10=unbearable pain)*
Now: ___/10 Average: ___/10 Best: ___/10 Worst: ___/10
What time of the day or week are your symptoms worse? ______________
How often are your symptoms present? ☐ Intermittently ☐ Occasionally ☐ Frequently ☐ Constant
Your symptoms usually last for ______ ☐ minutes ☐ hour(s) ☐ days ☐ week(s)
What daily activities have been affected? ______________
Have you received any treatment for this condition and if so what? ______________

If no more complaints please proceed to section B and C on page 2.

2nd Complaint ______________ Date Started ______________
What is the history of this injury or symptom?
____
____
____
What makes your problem worse? ______________
What makes your problem better? ______________
How would you describe your pain? ______________
What is the location or radiation of your pain? ______________
How bad is your pain on a scale of 0 to 10? *(0=no pain and 10=unbearable pain)*
Now: ___/10 Average: ___/10 Best: ___/10 Worst: ___/10
What time of the day or week are your symptoms worse? ______________
How often are your symptoms present? ☐ Intermittently ☐ Occasionally ☐ Frequently ☐ Constant
Your symptoms usually last for ______ ☐ minutes ☐ hour(s) ☐ days ☐ week(s)
What daily activities have been affected? ______________
Have you received any treatment for this condition and if so, what? ______________

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If no more complaints please proceed to section B and C.

3rd Complaint ______________________________ Date Started ______________

What is the history of this injury or symptom?

____

____

____

____

What makes your problem worse? ______________________________

What makes your problem better? ______________________________

How would you describe your pain? ______________________________

What is the location or radiation of your pain? ______________________________

How bad is your pain on a scale of 0 to 10? *(0=no pain and 10=unbearable pain)*

Now: ___/10 Average: ___/10 Best: ___/10 Worst: ___/10

What time of the day or week are your symptoms worse? ______________________________

How often are your symptoms present? ☐ Intermittently ☐ Occasionally ☐ Frequently ☐ Constant

Your symptoms usually last for _____ ☐ minutes ☐ hour(s) ☐ days ☐ week(s)

What daily activities have been affected? ______________________________

Have you received any treatment for this condition and if so, what? ______________________________

***Section B** Please use a <u>yes</u> or <u>no</u> when answering any of the following. If you are not sure leave a ?.*

___ Do you have a past history of cancer?
___ Have you had any unexplained weight loss?
___ Does your pain not improve with rest?
___ Are you over 50 years old?
___ No response to 4-6 weeks of conservative care?
___ Have you had spinal pain greater than 4 weeks?
___ *Recent trouble starting or stopping urination?*
___ *Trouble starting or stopping bowel movements?*
___ *Numbness in the groin region?*
___ *Increasing muscle weakness in the legs?*
___ History of significant trauma?
___ Minor trauma in person >50 years old?
___ Do you have osteoporosis (weak bones)?
___ Are you over 70 years old?
___ *Any* history *of* prolonged *use* of *corticosteroids*?
___ *Intravenous drug use?*
___ *Current or recent infection (urinary,respiratory, etc)?*
___ *Immunosuppression medication &/or condition?*

***Section C** Please circle your ability to perform the following work or home activities*

Routine/Activity	*ABLE*	*RESTRICTED*			*UNABLE*	*Routine/Activity*	*ABLE*	*RESTRICTED*			*UNABLE*
Sit in office chair	1	2	3	4	5	**Carry 100 feet**	1	2	3	4	5
Stand concrete	1	2	3	4	5	**Push**	1	2	3	4	5
Climb steps / stairs	1	2	3	4	5	**Pull**	1	2	3	4	5
Stoop to retrieve	1	2	3	4	5	**Balance**	1	2	3	4	5
Crouch to retrieve	1	2	3	4	5	**Crawl**	1	2	3	4	5
Kneel to retrieve	1	2	3	4	5	**Reach**	1	2	3	4	5
Reach overhead	1	2	3	4	5	**Handling**	1	2	3	4	5
Lift waist to shoulder	1	2	3	4	5	**Fingering**	1	2	3	4	5

Doctor/Staff notes: ______________________________

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____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ______________________________ Date ______________

Signature of patient (or parent of minor)

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PAST HISTORY

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PREVIOUS INJURIES *(Please give dates, describe injury and care received)*

AUTO: ____________________

WORK RELATED: ____________________

PERSONAL: ____________________

SPORTS INJURY: ____________________

OTHER: ____________________

MEDICAL HISTORY

GENERAL STATE OF HEALTH (Circle) Excellent, Good, Fair, Poor, Very poor
MEDICAL CONDITIONS: ____________________
PAST HOSPITALIZATIONS: ____________________
FRACTURES: ____________________
SURGICAL HISTORY: ____________________
MEDICATIONS/VITAMINS: ____________________
ALLERGIES (food, airborne, medicine): ____________________
VACCINATIONS ☐ Current ☐ Select exemptions ☐ Full exemption based on religious, medical or philosophical reasons

FAMILY HISTORY *(Please place the number of the family member and letter if applicable next to condition)*
[1. FATHER, 2. MOTHER, 3. SISTER (a, b, etc), 4. BROTHER (a, b, etc.)]

CANCER ____________________
DIABETES ____________________
HEART DISEASE ____________________
STROKE ____________________
HIGH BLOOD PRESSURE ____________________
EPELEPSY ____________________
MENTAL DISORDERS ____________________
TUBERCULOSIS ____________________
THYROID DIESASE ____________________
KIDNEY DISEASE ____________________
MUSCLE, BONE, OR NERVE DISEASE ____________________
RHEUMATOID ARTHRITIS ____________________
ANEMIA/BLOOD DISORDERS ____________________
RHEUMATIC FEVER ____________________
OTHER ____________________

PSYCHO-SOCIAL HISTORY
OCCUPATION (Circle): Professional/Technical, Tradesman, Clerical, Homemaker, Production, Service/Retail, Retired
Other ____________________
OCCUPATIONS (Please list your last 3 jobs with your current occupation listed first and circle responses)

DATE	OCCUPATION	HOURS	WC CLAIMS	DISABILITIES	ENJOYED
		FT/PT	Yes/No	Yes/No	Yes/No
		FT/PT	Yes/No	Yes/No	Yes/No
		FT/PT	Yes/No	Yes/No	Yes/No

SOCIAL HISTORY
MARITAL STATUS (Circle): Single, Married, Divorced, Widowed, Separated **CHILDREN #** _____
EDUCATIONAL LEVEL: ☐ < 12 years ☐ H.S. Grad. ☐ College (yrs:___) Degree: ____; Tech. (yrs___) Dipl.: ______

SOCIAL HABITS *(Please circle and check the appropriate responses and fill in the blanks)*
TOBACCO: ___ pack per ☐day ☐ week for ___ years; Chew ___ years; Pipe ___ years
CAFFEINE (SODA, COFFEE, TEA) ______ per ☐day ☐week ☐ month
ALCOHOL ____ glasses of ☐ wine ☐beer ☐mixed drinks per ☐day ☐ week ☐ month.
EXERCISE: Type: ______________ Freq. ___ per week; Duration _____ ☐minutes ☐ hours
SLEEP INTERRUPTED? ____ times per night for ____ ☐days ☐months ☐years

PLEASE FINISH NEXT PAGE

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REVIEW OF SYSTEMS

Please use the numbers below when answering. If you have never had the condition please leave blank.

1. Current
2. Past
3. Related to accident

GENERAL SYMPTOMS
___784.0 Headache
___780.6 Fever
___780.99 Chills
___780.8 Night Sweats
___780.2 Fainting
___780.4 Dizziness
___780.3 Convulsions
___780.52 Loss of Sleep
___780.7 Fatigue
___799.2 Nervousness
___783.0 Loss of Weight
___782.0 Numbness or pain in arms/legs/hands
___995.3 Allergy (What)
___786.07 Wheezing
___729.2 Neuralgia

MUSCLE & JOINTS
___728.9 Weakness
___781.0 Twitching
___723.5 Stiff Neck
___724.5 Backache
___719.0 Swollen Joints
___781.0 Tremors
___729.5 Foot Trouble
___724.79 Painful Tailbone
___724.5 Pain Between Shoulders
___737.3 Spinal Curvature

GASTRO-INTESTINAL
___783.0 Poor Appetite
___536.8 Poor Digestion
___994.2 Starvation
___787.3 Belching or Gas
___787.0 Nausea
___787.0 Vomiting
___578.0 Vomiting Blood
___536.8 Pain over Stomach
___564.0 Constipation
___787.91 Diarrhea
___562.1 Colon Trouble
___455.6 Hemorrhoids
___776.7 Fluid Retention
___873.9 Liver Trouble
___274.0 Gout
___782.4 Jaundice
___575.9 Gall - Bladder Trouble

CARDIO VASCULAR
___785.0 Rapid Heart
___427.89 Slow Heart
___401.9 High Blood Pressure
___458.9 Low Blood Pressure
___786.51 Pain Over Heart
___429.9 Heart Trouble
___719.07 Swelling Ankles
___459.9 Poor Circulation
___454.9 Varicose Veins
___436.0 Strokes
___785.1 Palpitations

EYE/EAR/NOSE/THROAT
___368.9 Poor Vision
___378.0 Crossed Eyes
___379.91 Pain in Eyes
___389.9 Deafness
___388.70 Earache
___388.30 Ear Noises
___388.60 Ear Discharges
___478.1 Nasal Obstruction
___784.7 Nose Bleeds
___462.0 Sore Throats
___784.49 Hoarsness
___477.9 Hay Fever
___493.9 Asthma
___460.0 Frequent Colds
___240.9 Enlarged Thyroid
___465.0 Tonsillitis
___473.0 Sinus Trouble

SKIN/ALLERGIES
___680.0 Skin Eruptions
___698.9 Itching
___924.9 Bruising Easily
___701.1 Dryness
___680.9 Boils
___782.0 Sensitive Skin
___708.9 Hives or Allergies
___692.9 Eczema

RESPIRATORY
___786.2 Chronic Cough
___786.2 Spitting Blood
___786.4 Spitting Phlegm
___786.5 Chest Pain
___786.09 Difficult Breathing

GENITO-URINARY
___788.4 Frequent Urination
___788.1 Painful Urination
___599.7 Blood in Urine
___590.0 Kidney Infection
___788.3 Bed Wetting
___788.3 Inability to control Urine
___601.9 Prostate Trouble

FOR WOMEN ONLY
___625.3 Painful Periods
___626.2 Excessive Flow
___626.4 Irregular Cycle
___627.2 Hot Flashes
___625.3 Cramps or Backaches
___623.5 Vaginal Discharge
_______ Last Pap Exam

Other conditions not listed above:

____

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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ Date______________

Signature of patient (or parent of minor)

PQRS Questionaire

Name:______________________________ Date:_________________________

Race/Ethnicity:

- White/Caucasian
- American Indian
- Hispanic/Latino Spanish Origin
- Black/African American
- Native Hawaiian
- Asian

Other_______________________

Language spoken:

English Spanish Chinese French Other

Do you have high blood pressure? YES / NO (circle one)

Do you have diabetes? YES / NO (circle one)

Do you take any medications? YES / NO (circle one)

If "YES" please list at least one you take: ____________________________________

____

Do you have any allergies? YES / NO (circle one)

If "YES" please list at least one you have: ____________________________________

____

Are you a smoker? YES / NO (circle one)

Height __________ft __________ in Weight ________________________

Blood Pressure ________________/______________ Pulse ______________

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 traction 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 other 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 ten 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 that 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.

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.

_________________	_________________	_________________
Printed name	Signature	Date

REQUIRED FEDERAL PRIVACY AUTHORIZATION AND CLINIC POLICY

10/01

Federal Guidelines to assure your privacy are strictly adhered to at Eastside Chiropractic. Eastside Chiropractic's clinic policies are actually more restrictive than federal law requires. The most important guidelines are described as follows:

Your privacy as a patient at this office is kept in the strictest of confidence. Only members of the staff that are qualified to and required by their job descriptions have access to your personal contact information and, perhaps more importantly, your health information. Eastside Chiropractic is required to release your health information under some circumstances, for example, to other health care providers we are coordinating care with or to your insurance company. Eastside Chiropractic will not release your private information to anyone who does not have a right to your information.

Eastside Chiropractic will need your authorization to contact you and leave messages for you to contact the office for reasons such as appointment reminders. Messages may be be left on:

Answering machines, voice mail or pagers.
With any person at your residence or workplace.
Via email.

Eastside Chiropractic will need your authorization to forward to you written pieces regarding issues such as:

Informational.
Health condition related.
Alternative treatment related.
Marketing materials (ie. business cards).

It is the policy of Eastside Chiropractic not to reveal any information about you to any outside marketing company. Any alteration to the privacy policy of Eastside Chiropractic will be provided to you, in writing, for your written consent. You may inspect or copy the information Eastside Chiropractic utilizes to contact you at any time.

Unfortunately, information that we disclose to qualified parties may be re-disclosed by them and no longer be protected by federal privacy rules. You may further request we not release information to specific individuals, companies or organizations and although we do not have to agree to your restriction if we do, the agreement is binding on us. You may revoke your consent to information release at anytime by written consent. However, information previously released by the date of your revocation is not subject to that authorization revocation. If you do not give Eastside Chiropractic authorization it will not affect the treatment Eastside Chiropractic provides to you or the methods we use to obtain reimbursement for your care.

I authorize Eastside Chiropractic to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this required Federal Privacy Authorization and Clinic Policy document.

Patient's Signature: ______________________________ Date: ________________________

Printed name: ____________________________________

Signature of personal representative/guardian: ____________________________________

Printed name of personal representative/guardian: ______________________________

Relationship of personal representative/guardian to patient: ___________________________