

RAND FAMILY CHIROPRACTIC

Please Print Clearly and fill in completely.

Print Name _____ Email _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Please Check Sex: Male Female Right handed Left handed Married Single

Health History:

Give reason for seeking chiropractic care: _____

Describe any health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No

If Yes, the conditions being treated for: _____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes No Who? _____

Wellness Commitment

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Where did you hear about our clinic,
or who referred you? _____

FEMALES: Please Check One Is there a possibility of you being pregnant? Yes No

Patient Primary Complaint Form

Name: _____ Date: _____

What is the number one thing that bothers you the most today? _____

How did your pain begin? _____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting Better or Getting worse

Is your condition: On & Off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore

Radiating: Left/Right base of skull shoulder arm hand
hip leg knee foot ribs other: _____

What makes it better? ice heat rest movement stretching

What makes is worse? sitting standing walking lying down sleep
overuse other: _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? Auto, Fall, Work, etc?

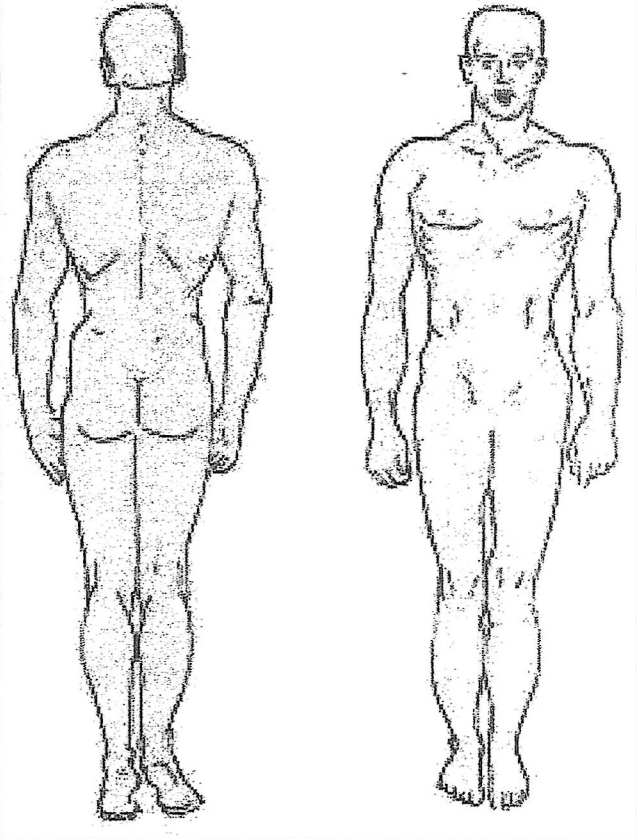
Do you have any other physical complaints? _____

Patient Signature: _____

Please Fill in Below If you have had the following, or if you suffer from the following, **Please Check** ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Thank you for being complete and thorough.
Your Signature Below Please

Date: _____

INFORMED CONSENT

Dear New Patient,

Every type of healthcare procedure and/or treatment is associated with some degree of risk. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic healthcare before consenting to treatment.

Chiropractic adjustments involve the moving of joints in the body with the use of the doctor's hands, use of a machine, use of a mechanical table, or use of a hand held instrument. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office, we use trained staff to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, and other treatment modalities. Occasionally when your doctor is unavailable, another chiropractor will treat you. If you do not want to be treated by another chiropractor in this clinic, please inform the staff immediately and that request will be honored.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All chiropractic physicians providing care at the **Rand Family Chiropractic** are licensed by the Chiropractic Physicians' Board of Arizona in accordance with state laws.

POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC PROCEDURES

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include:

- Stroke
- Vertebral disc herniation
- Soft tissue injury
- Rib fractures
- Physical therapy burns
- Soreness

I hereby give consent to the **Rand Family Chiropractic** and its employees and/or contract personnel to render treatment to myself and/or my child (or child under my guardianship). This includes all necessary examinations, treatment, and any other related procedures necessary to provide chiropractic care. I understand that treatment will be based on the physician's professional judgment.

PRINT NAME

SIGNATURE OF PATIENT / PARENT OR GUARDIAN

DATE