Total Health of Vero Beach New Patient Questionnaire

Patient Information

Please Print

Name____ Date______________

Address____City__________________State______Zip____________

Seasonal Address____City_______________State_____Zip________

Male Female Married Single Widowed Divorced Separated

Birthdate_____________Home Phone_______________Cell Phone_________________Work Phone____________

Email Address ____

Employer__________________________________Occupation_______________________________# years______

Spouse or Parent Name______________________________________Birthdate__________Phone #____________

Emergency Contact__________________________________Phone #_______________Relation______________

Name of Local Primary Physician____May we contact them?____

Who may we thank for referring you to us?____

Did you see our? Web Page?______ Facebook?______ Business Sign?_______ Word of mouth?________

Symptoms

Main complaint____When did it start_________________________

How did it start____

____

What activity bothers it most____Getting Better/Worse?____________

When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working

Rate the pain - (0 pain free – 10 unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Secondary Complaint____

Other chiropractors? _______________________ Positive experience?__________Last Visit?__________________

Other type of physician or therapist?_______________________Positive experience__________________________

Health History – Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthiritis	Asthmas	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken Pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart Dx
Hepatitis	Hernia	Herniated Disc	Herpes	Hi Cholesterol	Kidney Dx	Liver Dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Chronic Fatigue		Hi Blood Pressure	Fibromyalgia	Other______________________________________			

Women – How many children?______ Are you pregnant?______Date of Last Menstrual Cycle________________

Nursing?________ Taking birth control pills?_______

Previous surgeries and dates____

____

List all medication your are currently taking____

What kind of exercise do you do?____

What supplement do you take?____

How much do you smoke per day?______________ Drink per week?__________________

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous and can hinder treatment. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding money amount owed to this office.

Patient signature____ Date________________

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic treatment: The Doctor of Chiropractic may perform an examination of the area of complaint and **if medically necessary**, s/he may take radiographs in order to correctly diagnose the condition. The doctor uses their hands or a mechanical device to move your joints. You may hear a "click" or a "pop" similar to your knuckles cracking and you may feel the joint moving. Additional therapies such as myofascial release, ice, electric muscle stimulation or cold laser may also be used. The doctor will make a very reasonable effort during the examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. These complications could include but not limited to: fractures of bone, muscular strain, ligamentous strain, 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. Some patients may feel stiff and sore after the first few days of treatment.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as rare. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million.

Other Treatments which could be considered outside this office may include: over the counter analgesics and rest, medical care including medically prescribed anti-inflammatories, tranquilizers, analgesics, medical pain management including injections, hospitalization or surgery.

Risks of Remaining Untreated: Delay of treatment may allow the formation of adhesions, scar tissue, and other degenerative changes which can further decrease skeletal mobility and induce chronic pain cycles. Over time, this process may complicate the condition and make future rehabilitation more difficult.

I, ____, have read the above explanation of chiropractic treatment and will present any questions that I may have to the doctor. By signing below I state that I have weighed the risks involved in undergoing treatment. I have freely decided to undergo the recommended treatment and I give my full consent to treatment.

____
Date

____ ____
Patient's Signature Doctor's Name

____ ____
Signature of Parent/Guardian if Minor Doctor's Signature