Lower Cape Chiropractic Services

Date_____

Personal Information

Your Health Profile

NAME: PATIENT#: BIRTH DATE: AGE:

BILLING ADDRESS:

CITY / STATE / ZIP:

HOME PHONE #: WORK PHONE#: CELL#:

E-MAIL ADDRESS: MALE FEMALE OTHER

OTHER MAILING ADDRESS:

OCCUPATION EMPLOYER'S NAME AND ADDRESS:

SINGLE: MARRIED: DIVORCED: WIDOWED: SPOUSE/PARTNER NAME:

CHILDREN: NAMES, AGES & GENDER:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Your Health Profile

Why This Form Is Important:

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential .

Are you here for Wellness?_____ or A Specific Symptom or Complaint?_____

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History ." (next page)

Others, please briefly describe your chief concern, including the effect it has had on your life.

Health Concerns: *List health concerns according to their severity.*	Rate of Severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					

If you are experiencing pain, is it…

☐ Sharp ☐ Dull ache ☐ Tingling ☐ Numbness

Does the pain radiate anywhere? ☐ yes ☐ no

If yes, where? _____

Since the problem started, it is… ☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it worse? _____

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

☐ I do ☐ do not have a family history of this or similar symptoms (if you do, please explain)

_____

Is this condition interfering with your: ☐ Work ☐ Leisure ☐ Sleep ☐ Sports/exercise/walking,
☐ Positive mental attitude ☐ Hobbies ☐ Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

_____

If you felt fully well, what would you like to be doing that you are not doing now?

_____

Other Doctors seen for this condition: ☐ Chiropractor ☐ Medical Dr. ☐ Other

1. Name/Address: _____
   Date: _____ What was the diagnosis? _____
   What was done? _____
2. Name/Address: _____
   Date: _____ What was the diagnosis? _____
   What was done? _____

General History:

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking and why: **prescription** and **non-prescription** (vitamins, herbs, homeopathics…)

Have you had any surgeries? (Please include all surgeries)

Type: _____ Date: _____ Doctor: _____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type _____ Date _____ Hospitalized ☐ Yes ☐
2. Type _____ Date _____ Hospitalized ☐ Yes ☐
3. Type _____ Date _____ Hospitalized ☐ Yes ☐

Have you ever had x-rays taken? (if yes) When:_____ Where:_____

Area of body:_____

We have found that there are 6 interferences to full health and wellness. While you may feel only a physical pain or symptom, please answer the following about these 6 interferences:

1. Physical:
   1. Any recent trauma, falls, sports injuries? ____yes ____no
   if yes, explain: _____
   2. Do you have any scars on your body (from surgeries or injuries)? ____yes ____no
   if yes, explain: _____

2. Nutrition:
   1. Current habits: ____smoking ____alcohol ____soda ____broccoli ____white sugar ____caffeine ____meat ____missed meals ____other_____
   2. Do you feel you need some coaching with your nutrition/diet/food plan? ____yes ____no

3. Electromagnetics:
   1. Do you use: ____cell phone ____computer ____microwave oven ____hair dryer ____TV ____video games ____portable electronic devices ____other_____
   2. How many hours per week do you spend at a computer? _____
   3. Do you live near power lines? ____yes ____no

4. Toxins:
   1. Do you have any teeth fillings? ____yes ____no If yes, are they: ____metal ____ceramic
   2. Are you exposed to any chemicals on a regular basis? ____gasoline ____oil ____lead ____solvents ____paint/paint thinner ____cleaning solutions ____antiperspirant with aluminum ____Aluminum cookware ____nail polish/remover ____Teflon coated cookware ____other:_____

5. Allergies/Sensitivities:
   1. Do any foods bother your digestion? ____yes ____no. If yes, what?_____
   2. Have you had any food/allergy testing? ____yes ____no
   3. Do you have any airborne allergies? ____dust ____pollen ____mold ____other:_____
   4. Do you have any food cravings? ____ yes ____no. If yes, what?_____

6. Emotions/Psychological:
   1. Have you had any recent stressful events? ____death of loved one or pet ____move ____job change ____other:_____
   2. Do you tend to feel stress in your body? ____yes ____no.
   If yes, where? ____neck ____back ____headaches ____digestion ____other:_____
   3. Do you find any aspects of your life stressful? ____work ____family ____relationships ____finances ____other:_____

On a scale of 1-10, (1 being very poor / low & 10 being excellent / high) describe your:

Eating Habits:_____ Exercise Habits:_____ Sleep:_____ General Health:_____

Mind Set:_____ Personal Stress:_____ Job Stress:_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health conditions or concerns they may have:

Children: _____ Brothers: _____

Spouse: _____ Sisters: _____

Mother: _____ Others: _____

Father: _____

Insurance Information:

Do you have health insurance: ____yes ____no If yes, please give us your insurance card(s) to copy.

Please note that it is ***YOUR* responsibility to find out if you have chiropractic coverage on your Policy and what the deductible and copayment amounts are. Our office does not accept or process out of state or out of network insurance plans.

Was **this** injury the result of an accident? ____yes ____no

If yes: ____work ____auto ____other:_____ Date of accident:_____

_____(initial) ** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary report forms and assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____(initial) I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment

_____(initial) I authorize payment of medical benefits to Lower Cape Chiropractic for services described on the Health Insurance Claim Form

_____(initial) If my health plan is Blue Cross/Blue Shield, I understand that some office procedures such as xrays, examinations, nutritional supplements and supports may not be covered by my benefit plan today and on future office visits.

_____(initial) If my health plan is Medicare, I understand that Medicare ***only*** covers manual manipulation of the spine for ***acute*** care. Exams and x-rays are **not** covered by Medicare, nor is wellness or maintenance care. It is up to me to determine what coverage, if any, my secondary insurance covers.

_____(initial) We require you leave a credit card number on file so that any balances over 30 days can be automatically charged to it. MasterCard, Visa, or Discover Card (*NO American Express*)

Credit Card #_____ exp._____CVV:_____

Your name as it appears on card:_____ Billing Zip Code:_____

_____(initial) ** I acknowledge that I have read and understand Lower Cape Chiropractic's Office Policies, Informed Consent, and Privacy Pledge.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____Date: _____

Thank you for filling out this form. It is your first step to Creating Wellness!