

# Patient History

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY

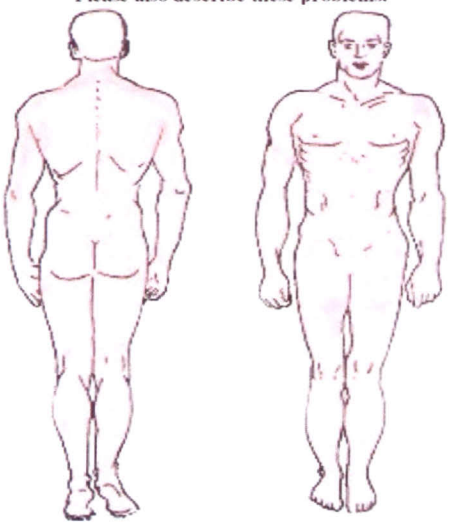
NAME \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_ MALE ( ) FEMALE ( )  
STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME # \_\_\_\_\_ CELL# \_\_\_\_\_ WORK# \_\_\_\_\_  
EMAIL: \_\_\_\_\_

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

## HEALTH HISTORY

REASON FOR VISIT/PROBLEM AREA(S) \_\_\_\_\_  
DATE OF ONSET \_\_\_\_\_ DURATION: DAYS ( ) MONTHS ( ) YEARS ( ) OTHER: \_\_\_\_\_  
# OF EPISODES: 0-3 ( ) 4-5 ( ) MORE THAN 5 ( ) HOW DID THE ISSUE BEGIN: \_\_\_\_\_  
TYPE OF PAIN: SHARP ( ) DULL ( ) SHOOTING ( ) THROBING ( ) TINGLING AND NUMBNESS ( )  
RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (MOST PAIN): \_\_\_\_\_  
HOW OFTEN DOES THE PAIN OCCUR: CONSTANT ( ) INTERMITTENT ( ) OCCASIONAL ( )  
WHAT MAKES IT WORSE: \_\_\_\_\_  
WHAT MAKES IT BETTER: \_\_\_\_\_  
IS THE CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?: \_\_\_\_\_  
THIS CONDITION INTERFERES WITH: WORK ( ) SLEEP ( ) ROUTINE ( ) OTHER ( )  
RESTRICTIONS OF DAILY LIVING ON A SCALE FROM 1 (NO LIMITS) TO 10 (TOTAL DISABILITY) \_\_\_\_\_  
IS THE CONDITION GETTING PROGRESSIVELY WORSE? YES ( ) NO ( ) EXPLAIN: \_\_\_\_\_  
MOVEMENTS THAT ARE PAINFUL: SITTING ( ) STANDING ( ) WALKING ( ) BENDING ( ) LYING DOWN ( )  
ARE YOU UNDER THE CARE OF ANY OTHER PHYSICIAN? YES ( ) NO ( ) NAME OF DOCTOR: \_\_\_\_\_  
ARE YOU USING ANY HOME REMEDIES?: \_\_\_\_\_  
LIST ANY CURRENT MEDICATIONS: \_\_\_\_\_  
DO YOU HAVE HIGH STRESS: YES ( ) NO ( ) REASON: \_\_\_\_\_

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



PLEASE FILL IN ANY OTHER HEALTH INFO  
YOU FEEL WE MIGHT NEED FOR YOUR CARE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**INJURIES/SURGERIES DESCRIPTION AND DATES**  
ACCIDENTS/FALLS \_\_\_\_\_  
BROKEN BONES \_\_\_\_\_  
SURGERIES \_\_\_\_\_  
OTHER \_\_\_\_\_  
\_\_\_\_\_

**IF YOU HAVE/HAD THE FOLLOWING, OR IF YOU SUFFER FROM THE FOLLOWING PLEASE CHECK**

Shortness of Breath	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Loss of Taste	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Loss of Balance	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Face Flush	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	Ringin/Buzzing Ears	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Lights Bother Eyes	<input type="checkbox"/>	Grating/Grinding Neck	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Cold Sweats	<input type="checkbox"/>	Limb Pain	<input type="checkbox"/>	Gout	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Neck Stiff	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>
Posture Issues	<input type="checkbox"/>	Slipped Disc	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>
Pins & Needles in Legs	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Tonsilitis	<input type="checkbox"/>
Pins & Needles in Arms	<input type="checkbox"/>	Exhaustion	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Cold Hands	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Cold Feet	<input type="checkbox"/>	Tension	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>
Numbness in Fingers	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Painful Menstruation	<input type="checkbox"/>
Numbness in Toes	<input type="checkbox"/>	Iritability	<input type="checkbox"/>	Irregular Menstruation	<input type="checkbox"/>
Stomach Upset/Nausea	<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	Other	<input type="checkbox"/>

<u>EXERCISE</u>		<u>WORK ACTIVITY</u>		<u>HABITS</u>	
NONE	<input type="checkbox"/>	SITTING	<input type="checkbox"/>	SMOKING	<input type="checkbox"/>
MODERATE	<input type="checkbox"/>	STANDING	<input type="checkbox"/>	ALCOHOL	<input type="checkbox"/>
DAILY	<input type="checkbox"/>	LIGHT LABOR	<input type="checkbox"/>	COFFEE	<input type="checkbox"/>
HEAVY	<input type="checkbox"/>	HEAVY LABOR	<input type="checkbox"/>	OTHER	<input type="checkbox"/>

**PERSONAL AND FAMILY HISTORY**

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SPOUSES NAME: \_\_\_\_\_

SPOUSES HEALTH STATUS: \_\_\_\_\_

CHILDREN'S NAMES, AGES AND HEALTH STATUS: \_\_\_\_\_

**CHIROPRACTIC HISTORY**

HAVE YOU EVER BEEN TO A CHIROPRACTOR? \_\_\_\_\_ DOCTOR'S NAME \_\_\_\_\_

DATE OF LAST CHIROPRACTIC VISIT: \_\_\_\_\_ REASON FOR CARE: \_\_\_\_\_

DATE OF LAST CHIROPRACTIC XRAY: \_\_\_\_\_ HOW LONG WERE YOU UNDER CARE: \_\_\_\_\_

**WELLNESS COMMITMENT**

At De Saro Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. 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 you personal level of commitment toward obtaining and maintaining health and wellness.

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



## **Doctor-Patient Relationship in Chiropractic/Privacy Statement**

When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it's essential that they both are seeking and working towards the same goals. Chiropractic has one goal. It is therefore important that you understand the goal and our method to attain it. In this way there will be NO confusion, misunderstanding, or disappointment.

The purpose of Chiropractic is to restore and maintain the integrity of the spinal cord and its' nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine (called vertebra). Misalignments of the vertebra, which interfere with the functions of these pathways, are called **SUBLUXATIONS**. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

By means of a Chiropractic **ADJUSTMENT**, subluxations are corrected (reduced). Thus, the normal nerve function restores itself. The goal of Chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve supply over nerve pathways to every part of the body at all times.

This allows the body's inborn, innate healing ability to work to maximum efficiency. With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the Chiropractor does not offer to heal or treat it. The Chiropractor's only goal is to allow the body to heal itself and his only means is the correction of the vertebral subluxation.

Please understand that Chiropractic is **NOT** a substitute for medical treatments of any kind. Also, **NO** statement of the chiropractor is intended as a medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnose disease and chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference, which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. If the patient is aware of any latent pathological defects, illness or deformities, which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained, in detail, upon request.

**De Saro Chiropractic Center**

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the **Health Insurance Portability and Accountability Act** of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is available at the front desk upon your request.

Just as in any good relationship, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

I, \_\_\_\_\_, have read the above, understand it fully and undertake

(Please Print Name)

Chiropractic care on this basis.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

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### CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr.'s De Saro, and whomever they may designate as their assistants to administer treatment as they so deem necessary to my \_\_\_\_\_,

\_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_