



# Lindenwoods Chiropractic

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Health Card Number (6 digit): \_\_\_\_\_ M/F Age: \_\_\_\_\_ Birth Date: (D/M/Y) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_ Are you pregnant Y/N Height \_\_\_\_\_ Weight \_\_\_\_\_

Status: S M W D Name of Spouse: \_\_\_\_\_ # of children: \_\_\_\_\_

Who referred you here or how did you learn of our office? \_\_\_\_\_

Have you been to a chiropractor before? Yes / No Date of last visit: \_\_\_\_\_

Name of last chiropractor: \_\_\_\_\_ Have you had spinal x-rays? Yes/No When? \_\_\_\_\_

## Health concerns:

What condition brought you to our office? \_\_\_\_\_

On a scale of 1-10 (10 being severe), how bad is the problem? \_\_\_\_\_ / 10

When did it start? \_\_\_\_\_ How? \_\_\_\_\_

Is it  getting better  getting worse  staying the same?

How would you describe the problem? \_\_\_\_\_

Are you taking medication for this condition? Yes / No

If yes, which medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Please mark all symptoms that apply. This will help us fully evaluate your state of health. At Lindenwoods Chiropractic our goal is that our patients succeed in THINKING, EATING, MOVING and HEALING; we believe this is what creates true health.

### THINK...*well*

- Depression
- Sleep problems
- Anxiety
- Poor memory
- Concentration problems
- Learning disability

### EAT...*well*

- Heartburn/indigestion
- Constipation/diarrhea
- Food allergy
- Belching/gas
- Liver/gallbladder trouble
- Colon trouble
- IBS/Crohns

### MOVE...*well*

- Painful joints
- Painful muscles
- Low back pain/stiffness
- Middle back pain
- Neck pain / stiff neck
- Jaw problems
- Painful tailbone

### HEAL...*well*

- Blurred vision
- Ringing in ears
- Sore throat/tonsillitis
- Thyroid problems
- Sinus problems
- Cancer
- Diabetes
- Fatigue
- Pneumonia
- Asthma

- Headaches
- Cold hands/feet
- Dizzy
- Pins n needles in hands/feet
- Heart surgery
- Heart medications
- Autoimmune disease
- Difficulty Breathing

- Chest pain
- Short of breath
- High Blood Pressure
- High Cholesterol
- Painful menstruation
- Seizures
- Frequent colds
- Chronic cough
- COPD
- Hot flashes

From the above conditions you marked, please describe the two most serious, **not including your major health concern.**

#1 \_\_\_\_\_

On a scale of 1-10 (10 being severe), how bad is the problem? \_\_\_\_ / 10

When did it start? \_\_\_\_\_ How? \_\_\_\_\_

Is it  getting better  getting worse  staying the same?

Are you taking medication for this condition? Yes / No Which medication: \_\_\_\_\_

#2 \_\_\_\_\_

On a scale of 1-10 (10 being severe), how bad is the problem? \_\_\_\_ / 10

When did it start? \_\_\_\_\_ How? \_\_\_\_\_

Is it  getting better  getting worse  staying the same?

Are you taking medication for this condition? Yes / No Which medication: \_\_\_\_\_

Most people have had literally dozens of impacts/stresses that can cause spinal misalignments. Knowing these stresses helps us understand how to help you in the best and fastest way.

Have you ever been in any auto accidents? Yes / No Please explain: \_\_\_\_\_

Have you had any other injuries or surgeries? Yes / No Please explain: \_\_\_\_\_

Please list any emotional traumas you have experienced:

What kind of work do you do daily? Sitting at a computer, heavy lifting, physical job, etc, please list:

### **Informed Consent to Chiropractic Adjustments and Care**

I hereby request and consent to receive chiropractic adjustments and other chiropractic procedures (if necessary), from the doctors of chiropractic in this clinic. I will have an opportunity to discuss with the Doctors the nature and purpose of chiropractic adjustments and care. I understand that results are not guaranteed. I further understand and am informed that as in all health care, there are some slight risks associated with chiropractic care. Doctors of Chiropractic and other health care practitioners who use spinal adjustment techniques are required to advise their patients of the following: on rare occasions, some patients have reported rib fractures, muscle strain, ligament sprains, and disc injuries following spinal adjustments. However, no scientific study has ever verified such injuries. Spinal adjustments are rarely associated with vertebral artery injuries. Such cases may cause stroke, sometimes with serious neurological impairment. The risk of injuries or complications to chiropractic care is substantially lower than that associated with many medical or other treatments, medications and procedures provided for symptoms like mine. I do not expect the doctor to be able to anticipate and explain all risks and complications. During the course of my care, I wish to rely on the doctor to exercise judgment in my best interest, based upon the facts known at the time. I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above procedures. I intend this consent to apply to all my present and future chiropractic care in this clinic.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_