# PATIENT INFORMATION SHEET
# CHESTNUT RIDGE CHIROPRACTIC & WELLNESS CENTER

### WHY THIS FORM IS IMPORTANT

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Name: _____ Age: _____ Date: ___/___/___

Address: _____City_____State_____Zip Code_____

Home Telephone ( ) _____Work Phone ( )_____ M_____F____

Email Address: _____

Social Security # _____ Birth date ___/___/_____

Martial Status Single _____ Married _____ Divorced_____ Widowed_____ No. of Children: _____

Occupation_____

Employer's Name and address _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

## YOUR HEALTH PROFILE

### THE BEGINNING YEARS (To AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

| YOUR CHILDHOOD YEARS | YES | NO | UNSURE |
|---|---|---|---|
| Did you have any childhood illnesses? | • | • | • |
| Did you have any serious falls as a child? | • | • | • |
| Did you play youth sports? | • | • | • |
| Did you take/use any drugs? | • | • | • |
| Did you have any surgery? | • | • | • |
| Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree) | • | • | • |
| Were you involved in any car accidents as a child? | • | • | • |

| | YES | NO | UNSURE |
|---|---|---|---|
| Was there any prolonged use of medicine such as antibiotics or an inhaler? | • | • | • |
| Did you suffer any other traumas? (physical or emotional) | • | • | • |
| Were you vaccinated? | • | • | • |
| As a child, were you under regular Chiropractic care? | • | • | • |

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**(Both Sides)**

| ADULT – (18 TO PRESENT) | YES | NO |
|---|---|---|
| Do/did you smoke? | • | • |
| Do/did you drink alcohol? | • | • |

| | YES | NO |
|---|---|---|
| Do/did you play any adult sports? | • | • |
| Do/did you participate in extreme sports? | • | • |

Have you been in any accidents? • • On a scale of 1-10 describe your stress level: (1=none/10=Extreme)

Have you had any surgery? • • Occupational _____

Personal _____

On a scale of Poor, Good, or Excellent describe your:

Diet_____Exercise_____Sleep_____General Health_____

**ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE**

If you have no symptoms or complaints, and are here for wellness services, please check here _____, "Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile." Others need to briefly describe the chief complaint, including the effect it has had on your life.

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If you are experiencing pain, is it….

• Sharp • Dull • Comes & Goes • Travels • Constant

Since the problem, it is …. • About the same • Getting better • Getting worse

What makes it worse:_____

Yes, it interferes with: • Work • Sleep • Sitting • Hobbies • Leisure

Other Doctors seen for this problem (please list)

- Chiropractor_____
- Medical Doctor_____
- Other_____

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

| | | | |
|---|---|---|---|
| • Headaches | • Pins & Needles in Legs | • Fainting | • Neck Pain |
| • Pins & 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 | • Upset Stomach |
| • Fatigue | • Depression | • Irritability | • Tension |
| • Sleeping Problems | • Stiff Neck | • Cold Hands | • Cold Feet |
| • Diarrhea | • Constipation | • Fever | • Hot Flashes |
| • Cold Sweats | • Sensitive Eyes | • Problem Urinating | • Heartburn |
| • Mood Swings | • Menstrual Pain | • Menstrual Irregularity | • Ulcers |

List any Medications you are taking_____

_____

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## *ASSIGNMENT AND RELEASE*

***I hereby authorize this clinic and it's doctor (s) to administer care as they so deem necessary and for insurance benefits to be paid to CHESTNUT RIDGE CHIROPRACTIC. I acknowledge that I am financially responsible for NONCOVERED SERVICES. I hereby authorize my Chiropractor to release any information required to support my claim.***

***I understand that my chiropractor is performing an analysis for determination of vertebral subluxation. Any care rendered is for the removal of vertebral subluxation, not necessarily for treatment of disease and musculoskeletal conditions.***

***Signature _____ Date _____***