TOTAL BACK AND BODY CENTER
CASE HISTORY

GENERAL INFORMATION

Date_____

Name:_____ **Sex**: ❑ **Male** ❑ **Female** **Height**_____**Weight**_____

Address:_____ **Birth Date**:____/_____/____ **Age**_____

City:_____ **ST**_____ **Zip**_____ **Social Security #**:_____-_____-_____

Home Number:(_____)_____ **Cell Phone**: (_____)_____**Email**:_____@_____
Would you like to get reminded of appointments? ❑ No ❑ Text to Cell Phone ❑ Email ❑ Phone Call

Martial Status: ❑Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Children #:____

Race: White Black Hispanic Asian Native American Other:_____ **Primary Language:** _____

Occupation:_____**Employer**: _____**Work#**:(_____)_____

Spouse Name:_____ **Occupation**:_____

Emergency Information: Emergency Contact:_____**Phone Number**:(_____)_____
Relationship to you? _____

Whom should we thank for referring you into our office?_____

Insurance Information: **Do you have insurance**? ❑ Yes ❑ No **Relation to insured** : ❑Self ❑Spouse

Insurance Company Name :_____

Primary Care Physician Name:_____ Last Visit _____Phone #:(_____)_____

COMPLAINTS:

Where are you currently having symptoms?_____
When did symptoms begin?_____ **Rate pain level on scale of 1 (least pain) to 10 (severe pain)** ____

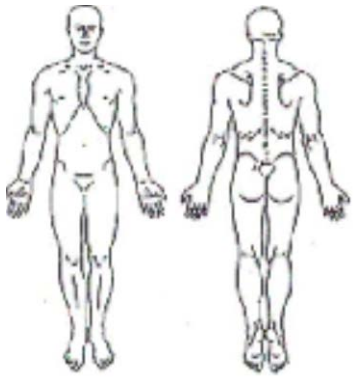
How did symptoms begin?_____

Is the condition getting worse? ❑ Yes ❑ No ❑ Unknown

The pain is? ❑Constant (76-100%) ❑Frequent (51-75%) ❑Occasional (26-50%)
❑ Infrequent (1-25%) ❑ Comes and Goes ❑ Vary with intensity and frequency

The symptoms are: ❑ same throughout the day
The symptoms are better in the morning / afternoon / night / sleeping
The symptoms are worse in the morning / afternoon / night / sleeping

Type of symptoms you are experiencing: (mark all that apply):
❑Dull ❑ Sharp ❑ Throbbing ❑Burning ❑Deep ❑Aching ❑ Tingling ❑Stabbing
❑Cramping ❑Soreness ❑ Numbness ❑Stiffness ❑Spasm ❑ Grabbing ❑Swelling
❑Pounding ❑Tightness ❑Shooting to _____ ❑Other :_____



Mark All Pain Areas

Activities that aggravate the pain: ❑ Sitting ❑Standing ❑Walking ❑ Bending ❑ Stooping ❑ Lifting ❑Sleeping
❑Straining ❑Reaching ❑Twisting ❑Looking Up/Down ❑Movements ❑Resting ❑Driving ❑Stairs ❑ Computer
❑ Housework ❑ Exercise ❑ Working ❑Sitting to Standing ❑ Standing to Sitting ❑Other:_____

What improves the pain: ❑Nothing ❑Sitting ❑ Standing ❑Lying ❑ Knees Bent ❑ Support (cane) ❑ Movement
❑ No Movement ❑ Heat ❑ Ice ❑ Topical Rub ❑ Over the counter Medication ❑ Prescription medication
❑Resting ❑Stretching ❑Exercising ❑Back Brace ❑Massage ❑Hot Showers ❑ Jacuzzi ❑Tens Unit ❑Other____

Since your symptoms began, have you had changes with: ❑None ❑Bowel ❑Sexual functions ❑Bladder

Have you had treatment already for your condition? ❑ No ❑ Self Treatment Only ❑ Yes What? _____
What physician(s) have you treated with for this Condition?_____
Specialty?_____ Date of consultations_____
What was treatment recommendation? ❑Muscle Relaxors ❑Anti-Inflammatories ❑Antibiotic ❑ Pain Medication
❑ Physical Therapy ❑ Surgery ❑ Chiropractic Care Other_____
Did Treatment help? ❑ No, Aggravated problem ❑ Yes, helped a little ❑ Yes, helped a lot ❑ No Symptoms
Were you referred to anyone from your doctor? ❑ No ❑ Yes Referred to:_____
For _____
Diagnostic Test and areas of tests that have been performed in past 5 years:
❑ X-Rays of the _____ ❑ MRI of the _____ ❑ CT scan of the_____
❑Bone Scan of _____ ❑ Bone Density test _____ ❑ Blood Work for_____
❑ EMG of _____ ❑ Nerve Conduction of_____Other:_____

CHIROPRACTIC CARE
Have you been to a Chiropractor before? ❑ No ❑ Yes Who?_____
How long ago was the last chiropractic treatment?_____**What was the treatment for**?_____
How were your results with chiropractic previously? ❑ Good ❑ Okay ❑ Bad Why?_____

HEALTH HISTORY (**P** = In The Past Only **H** = Have Right Now)

General	P	H
Bronchitis	❑	❑
Chills	❑	❑
Convulsions	❑	❑
Dizziness	❑	❑
Fainting	❑	❑
Fever	❑	❑
Loss of Sleep	❑	❑
Loss of Weight	❑	❑
Nervousness	❑	❑
Parkinson's DX	❑	❑
Night Sweats	❑	❑
Wheezing	❑	❑
Headaches	❑	❑
Heat Intolerance	❑	❑
Tremors	❑	❑
Fatigue	❑	❑
AIDS/ HIV	❑	❑
Cancer	❑	❑
Allergies	❑	❑
Females Only		
Painful Cramps	❑	❑
Vaginal Discharge	❑	❑
Irregular Cycle	❑	❑
Abnormal Bleeding	❑	❑
Hot Flashes	❑	❑
Miscarriages	❑	❑
Pregnancy	❑	❑
Last Pap_____	❑	❑
Breast Lumps	❑	❑

Skin	P	H
Rash	❑	❑
Redness	❑	❑
Itching	❑	❑
Dryness	❑	❑
Easily Bruise	❑	❑
Eczema	❑	❑
Hives/ Allergies	❑	❑
Sensitive Skin	❑	❑
Hair Changes	❑	❑
Nail Changes	❑	❑
Lung		
Chest Pain	❑	❑
Cough	❑	❑
Difficult Breathing	❑	❑
Spitting up Blood	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Psychological		
Anxiety	❑	❑
Depression	❑	❑
Mood Swings	❑	❑
Memory Loss	❑	❑
Phobias	❑	❑
Others_____	❑	❑
Anorexia	❑	❑
Drug Addiction	❑	❑

Muscle & Joints	P	H
Back Pain	❑	❑
Shoulder Pain	❑	❑
Neck Pain	❑	❑
Foot Trouble	❑	❑
Herniated Discs	❑	❑
Rheumatoid Arthritis	❑	❑
Scoliosis	❑	❑
Osteoporosis	❑	❑
Cardio-vascular		
Swollen Extremities	❑	❑
Murmur	❑	❑
Palpitations	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Stroke	❑	❑
Prev Heart Trouble	❑	❑
High Cholesterol	❑	❑
Anemia	❑	❑
Diabetes	❑	❑
Thyroid Problems	❑	❑
Genito-Urinary		
Frequent Urination	❑	❑
Blood in Urine	❑	❑
Unable to Hold Urine	❑	❑
Kidney Problems	❑	❑
Prostate Problems	❑	❑
Bedwetting	❑	❑
Gout	❑	❑
Sterility	❑	❑

Gastro-intestinal	P	H
Decreased Appetite	❑	❑
Increased Appetite	❑	❑
Abdominal Pain	❑	❑
Excessive Gas	❑	❑
Vomiting	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Gallbladder Trouble	❑	❑
Jaundice	❑	❑
Liver Trouble	❑	❑
Nausea	❑	❑
Colon Trouble	❑	❑
Hemorrhoids	❑	❑
Pain over Stomach	❑	❑
Excessive Hunger	❑	❑
Poor Digestion	❑	❑
Ulcers	❑	❑
Alcoholism	❑	❑
Eyes		
Pain R L	❑	❑
Discharge R L	❑	❑
Vision Trouble R L	❑	❑
Cataracts R L	❑	❑
Ears		
Pain R L	❑	❑
Discharge R L	❑	❑
Ringing R L	❑	❑
Hearing trouble R L	❑	❑

ANY OTHERS NOT LISTED ABOVE? _____
Are You PREGNANT? ❑ NO ❑ YES Due Date:_____ Do you have a PACEMAKER? ❑ NO ❑ YES

MEDICATIONS: Are you currently taking Medications? ❑ No (Please put the name of medication & dosage)

Medical Issue	Medication Name	Medical Issue	Medication Name	Medical Issue	Medication Name
❑ Cholesterol		❑ Diabetes		❑ High Blood Pressure	
❑ Heart		❑ Thyroid		❑ Birth control	
❑ Cortisone		❑ Inhalers		❑ Stomach	
❑ Hormones		❑ Pain		❑Anti-Depressants	
❑ Headache		❑ Arthritis		❑Osteoporosis	
❑ Anti-biotic		❑ Anxiety		❑ Muscle Relaxers	

❑ Any Other Medications being taken:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑ YES _____

VITAMINS: ❑No Vitamins ❑ Multivitamin ❑Glucosamine ❑ Chondroitin ❑Calcium ❑ Fish Oil ❑ Flaxseed
Vit D ❑ Vit B ❑ Vit E ❑ Joint Formula ❑Digestive Enzymes ❑ CoQ10 ❑ Other _____

PAST HISTORY:

SURGERIES: Have you had any type of surgeries? ❑ No

Surgery	When	Surgery	When	Surgery	When
❑ Tonsillectomy	_____	❑ Colon	_____	❑ Thyroid	_____
❑ Spine /Knee/ Hip	_____	❑ Appendix	_____	❑ Heart	_____
❑ Gall Bladder	_____	❑ Stomach	_____	❑ Kidney	_____
❑ Hernia	_____	❑ Sinus	_____	❑ Eye	_____

❑ Other Surgeries not listed:_____

CANCER: Type _____ When_____ Outcome to date: ❑ Cancer Free ❑ Remission ❑Ongoing

FEMALE: ❑ Breast _____ ❑ C-section _____ ❑ Hysterectomy _____

MALE: ❑ Prostate _____ ❑ Other: _____

INJURIES:	**When**	**What was Injured**		**When**	**What was Injured**
❑ Auto Accident	_____	_____	❑ Slip/Fall	_____	_____
❑ Work Related	_____	_____	❑ Other:	_____	

HOSPITALIZATIONS:

Have you ever been hospitalized? ❑ No ❑ Only with Surgeries ❑ Childbirth

Other Hospitalizations**:**_____

EXERCISE: ❑ **No Exercise** ❑ **Few times a year** ❑ **Sporadic**

❑ **Walking** for ___ min/hr ___x wk/mth ❑ **Biking** ___ min/hr ___x wk/mth ❑ **Yoga/Pilates** ___ min/hr ___x wk/mth

❑ **Weights** ___ min/hr ___x wk/mth ❑ **Stretching** ___ min/hr ___x wk/mth ❑ **Swimming** ___ min/hr ___x wk/mth

❑ **Hiking** ___ min/hr ___x wk/mth ❑ **Dancing** ___ min/hr ___x wk/mth ❑ **Golfing** ___ min/hr ___x wk/mth

❑ **Tennis** ___ min/hr ___x wk/mth **Other:**_____

Hobbies? ❑ Reading ❑ Fishing ❑ Gardening ❑Sewing ❑Cooking ❑Computers Others:_____

Work Type? ❑ No ❑ Student FT / PT ❑ Retired ❑ PT Work ❑ FT Work ❑ Stay at home Parent ❑ Other

Work Type Activities? ❑ Standing ❑Sitting ❑Light Activities ❑Heavy Activities ❑Repetitive Activities

❑Driving ❑Lifting ❑Bending ❑Carrying ❑Pushing ❑Pulling ❑Arms over head ❑Kneeling Other_____

Habits? ❑ Smoking, packs a day____ ❑ Alcohol, drinks per week____ ❑ Coffee, cups per day _____

❑ High Stress, reason_____ ❑ Recreational Drugs use, per month_____

Sleeping Habits? ❑ Side Sleeper- Right / Left / Both ❑ Back Sleeper ❑ Stomach Sleeper ❑ Pillow between Leg

# of Pillows ____ Hours of sleep per night?____ How do you sleep? ❑Restful ❑ Wake up every __hr ❑ Insomnia

FAMILY HISTORY: Has any one in your family had any of the following?

Please use these codes for answers: **M**= Mother **F**= Father **S**= Siblings **C**= Children **G**=Grandparents

Cancer_____	Diabetes_____	Heart Trouble_____	Stroke_____
Ulcers_____	Arthritis_____	Headaches_____	Asthma_____
Anemia_____	Hepatitis_____	Glaucoma_____	Suicide_____
Allergies_____	Epilepsy_____	Birth Defects_____	Alcoholism_____

High Blood Pressure_____ Multiple Sclerosis_____ Mental Illness _____

Good Health? M F S C G Still Living?❑ Yes M F S C G ❑ No M F S C G

Are there are any other complaints that may not have been addressed? _____

_____

All the information above is accurate and true as can be recalled at this time. The doctors cannot be held responsible for information that is not discussed on this form.

❑ **I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)**

PATIENT SIGNATURE:_____ DATE:_____

WITNESS SIGNATURE:_____DATE:_____

OFFICE POLICY

If the doctor accepts you as a patient, a specific treatment plan designed to meet your needs will be prescribed. It is important for you to follow your treatment plan to maximize your results and achieve healing.

If you must cancel a scheduled appointment, please give 24 hours' notice if possible, as this time has been reserved for you. If you do miss an appointment, please make up the visit during the same treatment week, as not to disturb your progress. There may be a $20.00 charge for appointments that are missed without cancellation for people who continually abuse of this policy, as per our discretion.

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic Healthcare Services. The Doctor of Chiropractic will use his/hers hands or mechanical device in order to adjust your spine. You may feel a "click" or "pop", such as the noise you hear if your knuckles are "cracked", and you may feel movement in the joints at that time. The doctor may use various ancillary procedures such as trigger points (arthrostim electric adjusting machine), hot or cold packs, electric muscle stimulation, therapeutic ultrasound, intersegmental traction, or cervical/lumbar mechanical or manual traction.

Informed Consent

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I will discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

Probability of any risk occurring: The risks of complication due to a chiropractic treatment may be described as "rare", about as often as complications from being hit by lightning or winning the lottery. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million. We take great care in making sure through proper screening that we reduce your risks even more than that. And the risk of adverse reactions due to the Ancillary procedures is also extremely "rare".

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fracture of bone, muscle strain, ligamentous sprain, dislocation of joints, or injury to the discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. Some patients may have some soreness and stiffness after the first few days of treatment. The Ancillary procedures could produce skin irritation, burns or minor complications. As it is stated above all these things could happen but the doctors don't expect them to for careful evaluation and screening procedures are in place to insure your safety. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. . Again, if is the responsibility of the patient to make it known or to learn through healthcare procedures whatever he/she is suffering from: latent pathology defects, illnesses, if deformities which would otherwise not come to the attention of the Doctor of Chiropractic. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Results

The purpose of Chiropractic services is to promote natural health care through the reduction of the vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedure. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions, which do not respond to Chiropractic care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definitive answers to all problems. Both have great strides in alleviating pain and controlling disease.

Risk of remaining untreated: Delay in treatment allows for formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. This can further complicate your condition and prolong treatment at another date and time.

TO THE PATIENT: Please discuss any questions with the Doctor before signing this statement of policy.

I have read the explanations above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated my risks and benefits of undergoing treatment, and hereby give my full consent to treatment.

I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

*****I acknowledge that that a copy of the NOTICE OF PRIVACY was on display as well as available at the front desk. I understand and if any question I am free to ask for assistance in reviewing the document and understand my privacy rights.**

PATIENT SIGNATURE_____**DATE**_____

WITNESS SIGNATURE_____**DATE**_____