Hornstein Family Chiropractic

## Confidential Patient Information


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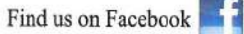


Date: ____________

First Name: ________________ Last Name: __________________ MI: ____

## Major Complaint Information

What is your major complaint(s)? ______________________________________________

______________________________________________

When did this symptom(s) begin? ______________________________________________

______________________________________________

How did this symptom(s) begin? ______________________________________________

______________________________________________

## On the illustrations below, mark the area where you are experiencing pain

Right Left Right

Describe the pain:

- ❍ Sharp
- ❍ Numbness
- ❍ Achy
- ❍ Stabbing
- ❍ Stiffness
- ❍ Other ________________
- ❍ Dull
- ❍ Tingling
- ❍ Burning
- ❍ Cramping
- ❍ Swelling

If this is an injury, describe what happened:

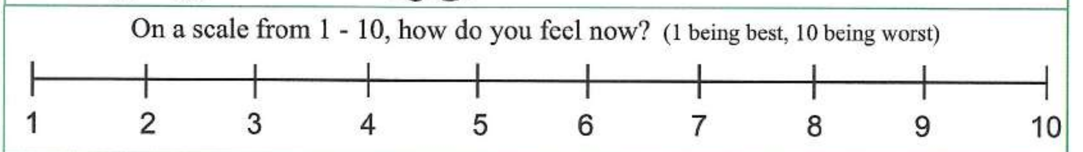
______________________________________________

______________________________________________

______________________________________________

______________________________________________

On a scale from 1 - 10, how do you feel now? (1 being best, 10 being worst)




Have you experienced this before? ❍ Yes ❍ No When? ____________________

Did it develop from? ❍ Auto Accident ❍ Work Related ❍ Other: ____________________

What aggravates this condition? ______________________________________________

What decreases the symptoms/pain? ______________________________________________

Does Tylenol, Ibuprofen, or Aspirin help? ❍ Yes ❍ No If so, how? ____________________

Does heat affect this? ❍ Yes ❍ No If so, how? ______________________________

Does cold affect this? ❍ Yes ❍ No If so, how? ______________________________

Have you seen a doctor for this condition? ❍ Yes ❍ No Doctor's Name: ____________________

Date Consulted: ____________________ Diagnosis: ____________________

Does this condition interfere with your sleep? ❍ Yes ❍ No If so, how many times do you wake up per night? ______________________________

In what position do you sleep? ❍ Back ❍ Side ❍ Stomach

Do you sleep with a pillow? ❍ Yes ❍ No If so, how many? ____________________

Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left

Does it cause pain to cough, grunt, or sneeze? ❍ Yes ❍ No If so, where? ____________________

## Check those injuries below during which you experience difficulty or pain:

| | | | | |
|---|---|---|---|---|
| ___ Lying on back or side | ___ Gripping | ___ Pushing/Pulling | ___ Lifting | ___ Standing for long periods |
| ___ Turning over in bed | ___ Dressing self | ___ Reaching | ___ Crossing legs | ___ Bending forward /backward |
| ___ Lying flat on stomach | ___ Sexual activity | ___ Kneeling | ___ Walking | Other: ___________ |
| ___ Getting in/out of a car | ___ Sleeping | ___ Sitting | | |

## Headaches

Do you get headaches? ❍ Yes ❍ No How often? _______________ Do you have a family history of headaches? ❍ Yes ❍ No

Do you experience the following along with your headaches: Pain or cracking in your jaw? ❍ Yes ❍ No

Abnormal blood pressure? ❍ Yes ❍ No ❍ High ❍ Low Nausea, Vomiting or Visual disturbance? ❍ Yes ❍ No

When was your last eye exam by a doctor? ❍ 1-6 months ❍ 6-12 months ❍ 1-2 years ❍ over 2 years Results: ___________

## Neck Pain

If you have neck pain, does it affect: (check all that apply) ❍ hearing ❍ vision ❍ balance ❍ cause ringing in your ears

Do you hear grating or popping sounds? ❍ Yes ❍ No Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you have difficulty lifting or turning your head? ❍ Yes ❍ No If so, in which direction? ❍ Right ❍ Left ❍ Up ❍ Down

## Lower Back Pain

If you have lower back pain, does the pain radiate to your abdomen? ❍ Yes ❍ No

Do you ever have unexplained loss of bowel or urinary function? ❍ Yes ❍ No

Have you ever been to a chiropractor before? ❍ Yes ❍ No Please list:

| Name of chiropractor: | Last Visit Date: | Name of chiropractor: | Last Visit Date: |
|---|---|---|---|
| | | | |

List all medications you are taking now, including over the counter medication, and supplement/vitamins:

______________________________________________

______________________________________________

Are you allergic to any medications: ❍ Yes ❍ No ❍ Not sure Please list: _______________

Do you smoke or chew tobacco? ❍ Yes ❍ No Do you drink any alcohol? ❍ Yes ❍ No

Any injuries or car accidents? ❍ Yes ❍ No Please list: _______________

Have you ever had any surgeries or hospitalization? ❍ Yes ❍ No Please list below:

| Type of Hospitalization/Surgery: | Date: | Type of Hospitalization/Surgery: | Date: |
|---|---|---|---|
| | | | |
| | | | |

Have you been x-rayed in the past? ❍ Yes ❍ No What Region? _______________

If female, are you pregnant? ❍ Yes ❍ No ❍ Not sure If yes, what is your due date? _______________

Do you have a family physician? ❍ Yes ❍ No Name of physician: _______________ Date of last physical: ___________

Practice physician is located: _______________

Have you been treated for any health conditions in the last year? ❍ Yes ❍ No If yes, explain: _______________

______________________________________________

## Additional Complaints

Please check all additional complaints that you have at this time:

| | | | | |
|---|---|---|---|---|
| ❍ Headache | ❍ Neck pain | ❍ Sinus trouble | ❍ Menstrual difficulties | ❍ Diabetes |
| ❍ Loss of concentration | ❍ Neck stiffness | ❍ Nervousness | ❍ Nausea | ❍ Allergies |
| ❍ Eyes sensitive to light | ❍ Neck motion restriction | ❍ Chest pain | ❍ Diarrhea | ❍ Hepatitis |
| ❍ Memory loss | ❍ Upper back pain/stiffness | ❍ Shortness of breath | ❍ Constipation | ❍ Convulsions |
| ❍ Heavy feeling of head | ❍ Mid back pain/stiffness | ❍ Loss of consciousness | ❍ Cold hands | ❍ Anemia |
| ❍ Dizziness | ❍ Lower back pain/stiffness | ❍ Irritable | ❍ Cold feet | ❍ Heart disease |
| ❍ Ringing in ears | ❍ Right/left shoulder pain | ❍ Anxiety | ❍ Jaw pain | ❍ Arthritis |
| ❍ Loss of balance | ❍ Right/left arm pain | ❍ Depression | ❍ Cuts | ❍ HIV (Aids) |
| ❍ Loss of smell | ❍ Right/left leg pain | ❍ Insomnia | ❍ Bleeding | ❍ Other (please list) |
| ❍ Loss of taste | ❍ Pins & needles arms/legs | ❍ Fatigue | ❍ Broken bones | ______ |
| ❍ Pain behind eyes | ❍ Numbness | ❍ Flushed face | ❍ Bruising | ______ |
| ❍ Fainting | ❍ Swelling | ❍ Excessive perspiration | ❍ Cancer | ______ |
| ❍ Palpitations | ❍ Vision problems | ❍ Digestive trouble | ❍ High blood pressure | ______ |

Do you have, or have you ever had, any diseases or medical problems not listed? ❍ Yes ❍ No

If so, please list: ______

Do you have a family history of disease or medical problems? ❍ Yes ❍ No

If so, please list: ______

Any additional information you would like the doctor to know about before beginning care at Hornstein Family Chiropractic?

______

## Personal Information

Name: ______

Address: ______ City/Sate/Zip: ______

Home Phone: ______ Cell Phone: ______

Email: ______

Birth Date: ______ Age: ______ Gender: ❍ Male ❍ Female Social Security Number: ______

Occupation: ______ Employer: ______

Work Address: ______ Work Phone: ______

May we call you at work? ❍ Yes ❍ No Home? ❍ Yes ❍ No Cell? ❍ Yes ❍ No

Marital Status: ❍ S ❍ M ❍ D ❍ W Spouse's Name: ______

Spouse's Occupation: ______ Spouse's Employer: ______ # of Children: ______

Children's Names: ______

How did you hear about our office? ______

## Emergency Information

Name of Contact: ______ Phone Number: ______

Place of Employment: ______ Phone Number: ______

# Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered 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 me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Hornstein Family Chiropractic to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Hornstein Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

**Specific Risk Possibilities Associated with Chiropractic Care.**

**Soreness-** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort after your treatment.

**Soft Tissue Injury-** Occasionally, chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury-** Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns-** Heat generated by physical therapy may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor or a staff member at Hornstein Family Chiropractic.

**Stroke-** is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Col. 37 No.2, Jun 1993) estimates that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments

**Other Problems-** There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature: Date:

I, as parent/legal guardian, give my informed consent for my child/minor to have chiropractic treatment administered.

Parent/Legal Guardian signature: Date: