

WELCOME TO JUERGENS CHIROPRACTIC

First Name _____ MI _____ Last _____ Birth Date ____ / ____ / ____ Age ____ Today's date ____ / ____ / ____
 Address _____ City _____ State _____ Zip _____
 Home # (____) _____ Work # (____) _____ Ext. _____ Soc. Sec. # _____ - _____ - _____
 Fax # (____) _____ Beeper/Cellular # (____) _____ E-mail Address _____
 ___ Male ___ Female # of Children _____ ___ Single ___ Married ___ Significant Other ___ Widowed ___ Separated ___ Divorced
 Your occupation _____ Work duties _____ **WOMEN ONLY: Are you pregnant? No ___ Yes ___**
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
 Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

YOUR HEALTH PROFILE

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

| | | | |
|--|-----------------------------|--|---------------------------|
| ___ Numbness/Tingling/Pain in (Arms / hands/ fingers) | | ___ Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) | |
| R / L Both R / L Both | | | |
| ___ Headaches/Migraines | ___ Hip Pain R / L | ___ Neck Stiffness/ Pain | ___ Back Stiffness/Pain |
| ___ Fractured Bones | ___ Arthritis | ___ Frequent Colds / Flu | ___ Diabetes |
| ___ Swollen Painful Joints | ___ Convulsions/Epilepsy | ___ Skin Problems | ___ Cancer |
| ___ Anemia | ___ Tremors | ___ Blurred Vision R / L | ___ Double Vision R / L |
| ___ Pain w/ Cough / Sneeze | ___ Chest Pain | ___ Lung Problems | ___ Loss of Taste |
| ___ Heart Problems | ___ Stroke | ___ Gall Bladder Problems | ___ Digestive Problems |
| ___ Prostate Problems | ___ Kidney Trouble | ___ Loss of Smell | ___ Loss of Balance |
| ___ Dizziness/Vertigo | ___ Buzzing/Ringing in ears | ___ Sinus Problems/Allergies | ___ Nervousness/Anxiety |
| ___ Fatigue | ___ Depression | ___ Irritability/Mood Swings | ___ Tension/Stress |
| ___ Colon Trouble | ___ Sleeping Problems | ___ Cold Hands | ___ Stomach Upset |
| ___ Cold feet | ___ Bed Wetting | ___ Recurring Infection | ___ Diarrhea/Constip./Gas |
| ___ Foot Problems | ___ Shortness of Breath | ___ Hot Flashes | ___ Jaw/TMJ Problems |
| ___ Cold Sweats | ___ Light Bothers Eyes | ___ Problems Urinating | ___ Heartburn/Reflux |
| ___ High Blood pressure | ___ PMS | ___ Menopause | ___ Ulcers |
| ___ Other _____ | | | ___ Cancer (Type) _____ |

Additional Explanation: _____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No

Was this due to an accident/Trauma? Yes No

If Yes, explain. (ex. fall, auto, sports,) _____

Symptoms: When this problem is at its worst, can you explain in your words how exactly it feels? _____

Severity Mild Moderate Severe

Does this pain travel or radiate? If so, Where? _____

Quality: (mark all that apply)

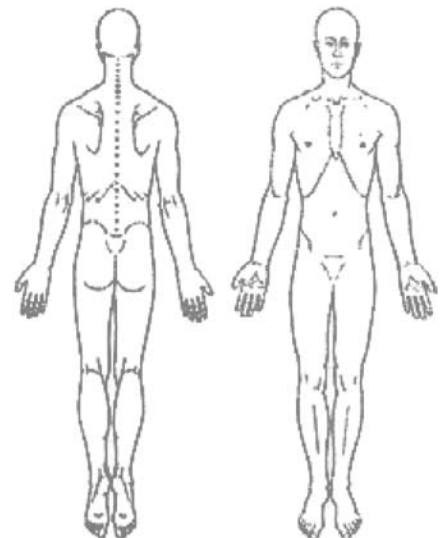
Burning Diffuse Dull/Aching Localized

Sharp Shooting Stabbing Tingling

Radiating Other _____

Is there anything that makes this better or worse? _____

Please mark on the diagram below the area of discomfort.



Patient Name: _____

Date: _____

Timing:

- Worse AM
 Worse PM
 Worse W/ Activity
 Worse Sleeping
 Occasional (0-25%)
 Intermittent (25-50%)
 Frequent (50-75%)
 Constant (75-100%)

How often do you find yourself suffering from this problem? _____

How long does the problem last? (all the details of timing) _____

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

| | | | | |
|-----------------------|------------------------------------|---|---|--|
| Carrying Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Changing Positions | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sit to Stand | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing Stairs | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pet Care | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Extended Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Household Chores | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting Children | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Reading/Concentration | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Bathing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Dressing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Shaving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sexual Activities | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting Still | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Standing Still | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard Work | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Please List any effects that this may have on any Recreational Activities: _____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions?

Is there anything else you think the doctor should know concerning your condition? Yes _____ No _____

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Signature

_____/_____/_____
Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

Signature

Date

PATIENT ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI)

To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

(Print name)

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided at the front desk. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Date