

WELCOME TO BARTHOLOMEW FAMILY CHIROPRACTIC!!!

PLEASE FILL IN ALL APPROPRIATE SPACES. ALL INFORMATION IS CONFIDENTIAL.

PATIENT HISTORY

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE _____

WORK PHONE: _____ BIRTHDATE: _____ AGE: _____

EMAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____

INSURANCE: _____ INSURED'S DOB: _____

SPOUSE/GUARDIAN: _____ CONTACT NUMBER: _____

MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____ OTHER _____

CHILDREN/AGES: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INTERESTS/HOBBIES: _____

Please provide us with a copy of your insurance card and drivers license, if applicable.

PLEASE MARK X FOR CURRENT CONDITIONS, O FOR PAST CONDITIONS

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> ACCIDENT/FALL | <input type="checkbox"/> AUTO ACCIDENT | <input type="checkbox"/> BACK CURVATURE | <input type="checkbox"/> BED WETTING |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> COLON TROUBLE | <input type="checkbox"/> CONVULSIONS/EPILEPSY |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIABETES | <input type="checkbox"/> DIGESTIVE ISSUES | <input type="checkbox"/> DIARRHEA/CONSTIPATION |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> EAR INFECTION | <input type="checkbox"/> FAINTING | <input type="checkbox"/> FOOT TROUBLE |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> FLU/COLD OFTEN | <input type="checkbox"/> GOUT | <input type="checkbox"/> HEADACHES/MIGRAINES |
| <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE |
| <input type="checkbox"/> HIP PAIN | <input type="checkbox"/> HERNIATED DISK | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> IMPOTENCE |
| <input type="checkbox"/> JAW PAIN/TMJ | <input type="checkbox"/> KIDNEY TROUBLE | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> LOW BACK PAIN/STIFFNESS |
| <input type="checkbox"/> MENOPAUSAL PROBLEMS | <input type="checkbox"/> MENSTRUAL PROBLEMS/PMS | <input type="checkbox"/> MID BACKPAIN/STIFFNESS | |
| <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> OSTEOPENIA/OSTEOPOROSIS | <input type="checkbox"/> UPPER BACKPAIN/STIFFNESS | |
| <input type="checkbox"/> PAIN/STIFF NECK | <input type="checkbox"/> PAIN W/SNEEZE/COUGH | <input type="checkbox"/> PINCHED NERVE | |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> PROSTATE ISSUES | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> SHOULDER PAIN |
| <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> SKIN PROBLEMS | <input type="checkbox"/> STROKE | <input type="checkbox"/> SWOLLEN/PAINFUL JOINTS |
| <input type="checkbox"/> THYROID ISSUES | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> TREMORS | <input type="checkbox"/> TROUBLE CONCENTRATING |
| <input type="checkbox"/> TUMORS/GROWTHS | <input type="checkbox"/> ULCERS | <input type="checkbox"/> TROUBLE SLEEPING | |
| <input type="checkbox"/> DIFFICULTY IN STANDING/WALKING/BENDING/RIDING/TWISTING/LIFTING | | | |
| <input type="checkbox"/> DIFFICULTY BREATHING/UPPER RESPIRATORY PROBLEMS | | | |
| <input type="checkbox"/> NUMBNESS/TINGLING/PAIN IN ARMS/HANDS/FINGERS | | | |
| <input type="checkbox"/> NUMBNESS/TINGLING/PAIN IN BUTTOCKS/LEGS/FEET | | | |

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT: _____

HOW LONG HAVE YOU HAD THIS CONDITION: _____ DATE OF ONSET: _____

IS THE CONDITION RELATED TO: WORK ___ AUTO ___ LOST DAYS FROM WORK? _____

WHAT DOCTORS HAVE YOU SEEN FOR THIS CONDITION? _____

WHAT DID THEY DO? _____

WHEN WAS YOUR LAST VISIT TO A CHIROPRACTOR? _____ PHYS THERAPIST? _____

WHAT SPINAL CORRECTION PROGRAMS WERE YOU GIVEN? _____

DID YOU FOLLOW IT? _____ DID IT HELP? _____

PRIMARY CARE PHYSICIAN: _____ DATE OF LAST EXAM: _____

DATE OF LAST X-RAY: _____ ARE YOU CURRENTLY WEARING: HEEL LIFTS _____

ARCH SUPPORTS _____ BACK BRACE _____

ARE YOU CURRENTLY PREGNANT? _____ DUE DATE: _____

PLEASE DESCRIBE FRACTURES, CANCER OR SURGERIES YOU HAVE HAD: _____

PLEASE LIST ANY DRUGS AND MEDICATION YOU ARE CURRENTLY TAKING
(PRESCRIPTIONS/SUPPLEMENTS/VITAMINS/ETC): _____

HABITS-WORK AND PERSONAL

EXERCISE HABITS: NONE _____ MODERATE _____ DAILY _____ HEAVY _____

WORK ACTIVITY: SITTING _____ STANDING _____ LIGHT LABOR _____ HEAVY LABOR _____

SMOKING _____ PACKS/DAY _____ *ALCOHOL* _____ DRINKS/WEEK _____

COFFEE/CAFFEINE _____ CUPS/DAY _____ *HIGH STRESS* _____ REASON _____

OTHER INFORMATION WE SHOULD BE AWARE OF: _____

Please fill in the following areas as applicable. Thank you.

PROBLEM AREA 1: _____

TYPE OF PAIN:

___ PAIN ___ NUMBNESS ___ SWELLING ___ MUSCLE SPASM ___ HEADACHE

___ TIGHTNESS ___ STIFFNESS ___ TINGLING ___ WEAKNESS

QUALITY OF PAIN:

___ SHARP ___ DULL ___ ACHING ___ THROBBING ___ CRUSHING ___ STABBING

___ LOCAL ___ RADIATING ___ BURNING ___ MIGRAINE ___ TENSION ___ HORMONAL

TIMING:

CONSTANT FREQUENT INTERMITTENT OCCASSIONAL INFREQUENT

ACTIVITIES LIMITED:

SITTING STANDING WALKING BENDING SLEEPING DRIVING
 DOING CHORES DURING COMPUTER WORK RECREATION DRESSING
 CARRYING LIFTING WORKING

PAIN IS WORST: IN THE MORNING MIDDAY AT NIGHT CONSISTENT ALL DAY

SEVERITY: AT BEST AT WORST (0-10) Please use the following scale:

NO PAIN (0) VERY MILD PAIN (1) MILD PAIN (2) VERY TOLERABLE PAIN (3) TOLERABLE PAIN (4) SOMEWHAT MODERATE PAIN (5) MODERATE PAIN (6) MODERATE-SEVERE PAIN (7) SEVERE PAIN (8) VERY SEVERE PAIN (9) DISABLING PAIN (10)

PROBLEM AREA 2: _____

TYPE OF PAIN:

PAIN NUMBNESS SWELLING MUSCLE SPASM HEADACHE
 TIGHTNESS STIFFNESS TINGLING WEAKNESS

QUALITY OF PAIN:

SHARP DULL ACHING THROBBING CRUSHING STABBING
 LOCAL RADIATING BURNING MIGRAINE TENSION HORMONAL

TIMING:

CONSTANT FREQUENT INTERMITTENT OCCASSIONAL INFREQUENT

ACTIVITIES LIMITED:

SITTING STANDING WALKING BENDING SLEEPING DRIVING
 DOING CHORES DURING COMPUTER WORK RECREATION DRESSING
 CARRYING LIFTING WORKING

PAIN IS WORST: IN THE MORNING MIDDAY AT NIGHT CONSISTENT ALL DAY

SEVERITY: AT BEST AT WORST (0-10) Please use the above scale.

PROBLEM AREA 3: _____

TYPE OF PAIN:

PAIN NUMBNESS SWELLING MUSCLE SPASM HEADACHE
 TIGHTNESS STIFFNESS TINGLING WEAKNESS

QUALITY OF PAIN:

SHARP DULL ACHING THROBBING CRUSHING STABBING
 LOCAL RADIATING BURNING MIGRAINE TENSION HORMONAL

TIMING:

___CONSTANT ___FREQUENT ___INTERMITTENT ___OCCASSIONAL ___INFREQUENT

ACTIVITIES LIMITED:

___SITTING ___STANDING ___WALKING ___BENDING ___SLEEPING ___DRIVING
___DOING CHORES ___DURING COMPUTER WORK ___RECREATION ___DRESSING
___CARRYING ___LIFTING ___WORKING

PAIN IS WORST: ___IN THE MORNING ___MIDDAY ___AT NIGHT ___CONSISTENT ALL DAY

SEVERITY: ___AT BEST ___AT WORST (0-10) Please use the above scale.

GOALS FOR MY HEALTH

At Bartholomew Family Chiropractic, our goal is to teach the families of our community how to be healthy through natural chiropractic care. In order for you to reach your maximum level of health, we have to work together. Please circle at least 3 goals below.

- | | | |
|---|--------------------------------------|-------------------------------|
| Eat ___ healthy meals a week (21/wk) | Eat veggies at ___ meals a day | |
| Exercise ___ times a week | Make time for me ___ times a week | |
| Decrease my smoking by ___ a day | Decrease my drinking by ___ a week | |
| Meditate ___ times a week | Have spiritual time ___ times a week | |
| Read ___ times a week | Journal/write ___ times a week | |
| Improved Posture | Improved Lifestyle | Increased Energy |
| Enjoy the best possible Life, Pain free | Improved ability to focus | Improved Sleep |
| Improved flexibility and strength | Overall Wellness | Live to be 100 in Good Health |
- Other : _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____
And assign directly to Dr. Bartholomew all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Name of Insured: _____

Relationship to Patient: _____

Signature of Patient, Parent, Guardian or Personal Representative:

_____ Date: _____

BARTHOLOMEW FAMILY CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC CARE AND 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 for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not diagnose or treat any disease or condition other than vertebral subluxation. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date
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Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____
Signature: _____ Date: _____

In case of emergency, please notify: _____ Phone: _____