PERSONAL INFORMATION & HEALTH HISTORY

OFFICE USE ONLY

DATE_____ CHART # _____ CASE # _____

PATIENT NAME_____ REFERRED BY_____

MAILING ADDRESS_____ CITY_____ ZIP_____

STREET ADDRESS_____ CELL PHONE ( ) _____

HOME PHONE ( )_____ WORK PHONE ( )_____ EXT_____

E-MAIL_____ MARITAL STATUS _____ CHILDREN_____

SSN _____ BIRTHDATE_____ SEX _____

OCCUPATION/EMPLOYER OR STUDENT/SCHOOL _____

BUSINESS ADDRESS_____

NAME OF YOUR MEDICAL DOCTOR _____

_____

YOUR CHIEF CONCERN(S)

1.) What health concern(s) would you like our help with?

2.) Describe how you feel (sharp pain, ache, burn, etc.)

3.) When did you first start feeling this way?

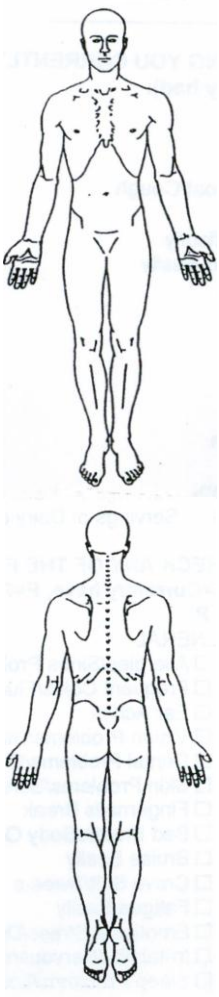
4.) What caused you to start feeling this way

5.) What helps you feel better?

6.) What causes you to feel worse?

7.) What have you done to treat this condition?

Please mark the location of your health concern(s) on the pictures



Please Turn Over

WELLNESS HISTORY

NAME_____**Date**_____

8.) Have you had Chiropractic care before? YES/NO

9.) What are your GOALS for care? (Mark all that apply)
- ☐ HELP ME STAY AS HEALTHY AS I AM
- ☐ HELP ME FEEL BETTER THAN I EVER HAVE
- ☐ HELP ME GET BACK TO "NORMAL"
- ☐ Other _____

10.) What type of TREATMENT(S) do you think you might be interested in? (Mark all that apply)
- ☐ CHIROPRACTIC ADJUSTMENTS
- ☐ MUSCLE/SPORTS THERAPY
- ☐ DETOX/CLEANSING ☐ DIET
- ☐ HERBS/SUPPLEMENTS
- ☐ CRANIOSACRAL THERAPY
- ☐ ACUPRESSURE ☐ MASSAGE
- ☐ ENERGY HEALING/REIKI

11.) Is there a time in your life when you began feeling significantly less healthy? YES/NO

12.) Are there any major decisions confronting you or your family at this time? YES/NO

13.) Are you satisfied with:
Family life: YES/NO
Social life: YES/NO
Friendships: YES/NO

14.) What are the major sources of stress in you life?

15.) Are you pregnant? YES/NO

16.) Describe your use of: (How many times per week)

Cigarettes/Tobacco _____

Caffeine (Coffee, Tea, Soda) _____

Alcohol _____Other drugs _____

17.) How many times per month do you take

ASPIRIN? _____ IBUPROFEN? _____

TYLENOL? _____ ANTACIDS? _____

LAXATIVES? _____ ALLERGY DRUGS _____

18.) What other prescription and over-the-counter drugs are you taking?

19.) What supplements are you currently taking? (vitamins, herbs, homeopathic, etc.)

20.) What illnesses, diagnoses or conditions are you currently living with?

21.) List all significant past injuries and illnesses (major or chronic), surgeries, and hospitalizations:

FAMILY HEALTH HISTORY

22.) Which family members had or have the same or similar conditions as yours:

23.) Please list major health history for your parents, siblings, & grandparents (ex. heart, stroke, etc.)

EXERCISE

24.) What do you do for exercise?

DIET

25.) Describe your daily diet? (low fat, vegan, etc)

26.) Servings of Fruits/Veg each day _____

27.) Ounces of Water each day _____

28.) Servings of Dairy each day _____

29.) Servings of Sweets each day _____

30.) Food Allergies/Sensitivities:

GENERAL HEALTH HISTORY

NAME_____**Date**_____

CHECK ANY OF THE FOLLOWING YOU CURRENTLY HAVE OR HAD IN THE PAST
(C=Currently have, P=Previously had):

C P
GENERAL
☐ ☐ Allergies/Sinus Problems
☐ ☐ Frequent Colds/Flu/Sore Throat/Cough
☐ ☐ Ear Aches
☐ ☐ Vision Problems/Hearing Difficulty
☐ ☐ Dental Problems/Gums Bleed Easily
☐ ☐ Skin: Bruising/Sores/Lumps/Eczema/Acne
☐ ☐ Fingernails Break
☐ ☐ Bad Breath/Body Odor
☐ ☐ Crave Salt/Sweets
☐ ☐ Fatigue Easily
☐ ☐ Emotional Stress/Depression
☐ ☐ Irritability/Nervousness
☐ ☐ Sleep Problems/Loss of Sleep

DIGESTION
☐ ☐ Poor or Excessive Appetite/Thirst
☐ ☐ Nausea/Vomiting
☐ ☐ Diarrhea/Constipation/Colitis/ Hemorrhoids
☐ ☐ Gas/Bloating/Cramping
☐ ☐ Heartburn/Indigestion/Burping/Belching
☐ ☐ Black or Bloody Stools
☐ ☐ Weight Gain or Loss

HEART & LUNGS
☐ ☐ Chest Pain/Shortness of Breath/Asthma
☐ ☐ Lung Problems/Lung Congestion/Pneumonia
☐ ☐ Heart Problems/Irregular Beat
☐ ☐ High Blood Pressure/Cholesterol
☐ ☐ Varicose Veins/Ankle Swelling

MUSCULOSKELETAL
☐ ☐ Headaches/Neck Pain or Arm Pain
☐ ☐ Shoulder Pain/ Rotator Cuff
☐ ☐ Back. Low Back or Leg Pain
☐ ☐ Hip/Knee or Foot Pain
☐ ☐ Joint Pain/Stiffness (Anywhere)
☐ ☐ Jaw Pain/Tight/Pops/Locks/Clenching/Grinding

NERVOUS SYSTEM
☐ ☐ Tingling or Numbness
☐ ☐ Convulsions, Seizures, or Paralysis
☐ ☐ Dizziness/Fainting
☐ ☐ Forgetfulness/Confusion
☐ ☐ Concussions/Head Trauma

C P
FEMALE
☐ ☐ Menstrual Irregularity/Cramping/Clotting
☐ ☐ Premenstrual Symptoms (PMS)
☐ ☐ Breast Pain/Lumps
☐ ☐ Vaginal Pain/Infection/Discharge/Drying
☐ ☐ Hot Flashes/Menopause Symptoms
☐ ☐ Loss of Sex Drive or Interest
# of Pregnancies _____# of Births ___

GENITAL & URINARY
☐ ☐ Bladder Trouble/Urinary Tract Infections
☐ ☐ Painful/Excessive/Discolored Urination
☐ ☐ Sexually Transmitted Disease

MALE
☐ ☐ Loss of Sex Drive
☐ ☐ Prostate Trouble/Erection Trouble

CHILDRENS HEALTH HISTORY

Birth: ☐ Premature ☐ Vaginal ☐ C-Section
Medical Problems After Delivery? ☐ Yes ☐ No

Ever seen a medical specialist? ☐ Yes ☐ No

☐ ☐ Bed Wetting
☐ ☐ Scoliosis
☐ ☐ Meningitis/Ear Infections/Strep Throat
☐ ☐ Anemia/Leukemia/Cancer
☐ ☐ ADHD/Anxiety/OCD/Depression
☐ ☐ Autism/Delayed Speech/Language/Motor Skills/
☐ ☐ Special Education/Dyslexia
☐ ☐ Ear Tubes/Hearing Loss
☐ ☐ Lazy Eye/Blurred Vision

Care/Education:
☐ At Home ☐ Day Care ☐ Pre-School
☐ Grade _____ ☐ Home School

Parents:
☐ Married ☐ Single/Live Together
☐ Single-Parent ☐ Divorced

Home Environment:
☐ House ☐ Apartment
Smokers: ☐ Yes ☐ No ☐ Inside ☐ Outside
Pets: ☐ Yes ☐ No

Please Turn Over

CONSENT, AGREEMENTS, & RELEASE

INFORMED CONSENT TO EXAMINATION, CHIROPRACTIC ADJUSTMENTS AND CARE:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patients named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now, or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below 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.

_____ _____

Patient initials Witness

FINANCIAL AGREEMENT

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment on the day of service, unless other written arrangements have been made between me and this office. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am responsible for payment of all charges not covered by my policy. If I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ _____

Patient initials Witness

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to Rick Schlussel, DC (PO Box 6686, Auburn, CA 95604) for all professional services rendered to me by his office. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it c/o Rick Schlussel, DC, PO Box 6686, Auburn, CA 95604. This instruction to you is a direct assignment of my rights and benefits under this policy to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

PATIENT SIGNATURE_____ DATE_____

PATIENTS REPRESENTATIVE (Print)_____ DATE_____

SIGNATURE OF REPRESENTATIVE_____ DATE_____