PERSONAL INFORMATION & HEALTH HISTORY

DATE_____

PATIENT NAME_____ REFERRED BY_____

MAILING ADDRESS_____ CITY_____ ZIP_____

STREET ADDRESS_____ CELL PHONE ( ) _____

HOME PHONE ( )_____ WORK PHONE ( )_____ EXT_____

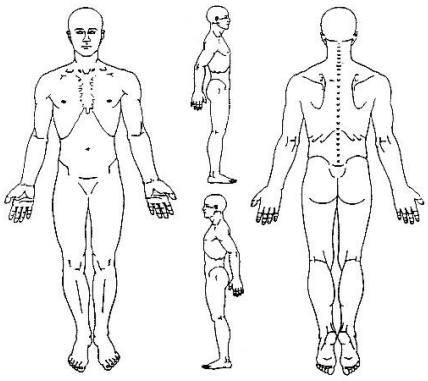
E-MAIL_____

BIRTHDATE_____ SEX _____ MARITAL STATUS _____ CHILDREN_____

OCCUPATION/EMPLOYER OR STUDENT/SCHOOL _____

NAME OF YOUR MEDICAL DOCTOR _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other _____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____
How Problem Began_____

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

In general your current overall health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken _____ What areas were taken? _____

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain) _____

☐ Prostate Problems, Erection Trouble
☐ Menstrual Problems
☐ Urinary Problem: Pain/Difficult/Excess, Color, Infection
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
☐ Tobacco Use - Type _____
Frequency /Day _____
☐ Medications _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

CONSENT, AGREEMENTS, & RELEASE

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient initials _____ Witness _____

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 Richard Schlussel, DC and any 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 Richard 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 Richard 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_____

NAME_____**Date**_____

HEALTH HISTORY

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

2.) What TREATMENT(S) are you interested in?
- ☐ CHIROPRACTIC ADJUSTMENTS
- ☐ MASSAGE/MUSCLE/SPORTS THERAPY
- ☐ DETOX/CLEANSING/DIET
- ☐ HERBS/SUPPLEMENTS
- ☐ CRANIOSACRAL THERAPY
- ☐ ENERGY HEALING/REIKI/ACUPRESSURE

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

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

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

6.) Which Over-The-Counter drugs and Supplements do you use?

DIET & EXERCISE

1.) What do you do for exercise?

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

3.) Servings of Fruits/Veg each day _____
4.) Ounces of Water each day _____
5.) Servings of Dairy each day _____
6.) Servings of Sweets each day _____
7.) Food Allergies/Sensitivities:

GENERAL HEALTH

C=Currently have, P=Previously had:

C P
- ☐ ☐ Allergies or Sinus Problems
- ☐ ☐ Frequent Colds, Flu, Sore Throat or Cough
- ☐ ☐ Ear, Vision, or Dental Concerns
- ☐ ☐ Skin: Bruising, Sores, Lumps, Eczema
- ☐ ☐ Fatigue
- ☐ ☐ Sleep: Difficulty, Interrupted, Lack
- ☐ ☐ Stress, Depression, Irritability, Nervous, Anxiety

- ☐ ☐ Appetite/Thirst: Poor or Excessive
- ☐ ☐ Nausea or Vomiting
- ☐ ☐ Diarrhea, Constipation, Colitis, or Hemorrhoids
- ☐ ☐ Gas, Bloating or Cramping
- ☐ ☐ Heartburn, Indigestion, Burping or Belching
- ☐ ☐ Black or Bloody Stools

C P
- ☐ ☐ Chest Pain or Shortness of Breath
- ☐ ☐ Asthma
- ☐ ☐ Heart Condition
- ☐ ☐ Varicose Veins or Ankle Swelling

- ☐ ☐ Headaches, Neck, Back, Shoulder or Arm Symptom
- ☐ ☐ Low Back, Leg, Hip, Knee or Foot Symptoms
- ☐ ☐ Jaw: Pain, Tight, Pops, Lock, Clenching or Grinding
- ☐ ☐ Tingling or Numbness
- ☐ ☐ Forgetfulness or Confusion
- ☐ ☐ Concussions or Head Trauma

- ☐ ☐ Menstrual: Irregularity, PMS, Cramping or Clotting
- ☐ ☐ Breast: Pain or Lumps
- ☐ ☐ Hot Flashes or Menopause Symptoms

Visual Analog Pain Scale

Name _____ **Date** _____

Example: Knee

No Pain — Pain as bad as it could possibly be

1st Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience

2nd Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience

3rd Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience

4th Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience