

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. other: _____

Last: _____ First: _____ Middle: _____

Birth Date: ___/___/___ Sex: Male / Female

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ ext _____ Cell Phone: (____) _____ - _____ ext _____

Email Address: _____

Spouses Name: _____ Health : _____

Children (Names and Ages): _____ Health : _____

Hobbies/ Interests _____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Internet/ Whole Life website Yellow pages Drove by Physician Insurance Plan

Emergency Contact

Name: _____

Phone # (____) _____ - _____ Relationship: Spouse Relative Friend Other _____

Employment Information

Business Name: _____

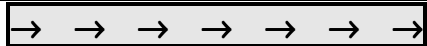
Occupation/Job Title and Description: _____

Current Health Condition

Unwanted Condition (s)/Why you are here today?: _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ___/___/___

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

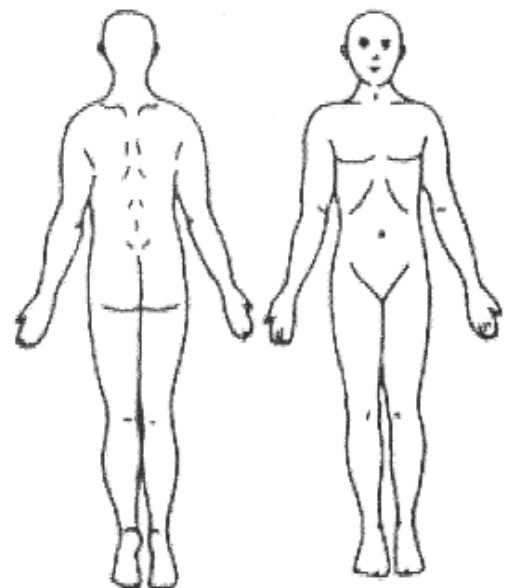
Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Please check the boxes that apply OR check the "I deny" box if none apply.

Constitutional:

- chills fatigue night sweats weight loss
 daytime drowsiness fever weight gain none of these

Eyes/Vision:

- blindness change in vision field cuts photophobia
 blurred vision double vision glaucoma tearing
 cataracts eye pain itching wear glasses/contacts
 none of these

Ears, Nose and Throat:

- bleeding ear drainage hearing loss nosebleeds sore throat
 dentures ear pain history of head injury postnasal drip tinnitus
 difficulty swallowing fainting hoarseness rhinorrhea (runny nose) TMJ problems
 discharge frequent sore throats loss of sense of smell sinus infections none of these
 dizziness headaches nasal congestion snoring

Respiration:

- asthma coughing up blood sputum production none of these
 cough shortness of breath wheezing

Cardiovascular:

- angina (chest pain or discomfort) high blood pressure shortness of breath with exertion or exercise
 chest pain low blood pressure swelling of legs
 claudication (leg pain/ache) orthopnea (difficulty breathing lying down) ulcers
 heart murmur palpitations varicose veins
 heart problems paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) none of these

Gastrointestinal:

- abdominal pain diarrhea indigestion abnormal stool vomiting blood
 belching difficulty swallowing jaundice abnormal stool color none of these
 black - tarry stools heartburn nausea abnormal stool consistency
 constipation hemorrhoids rectal bleeding vomiting

Female:

- birth control cramps irregular menstruation vaginal bleeding
 breast lumps/pain frequent urination pregnancy vaginal discharge
 burning urination hormone therapy urine retention none of these

Male:

- burning urination frequent urination prostate problems
 erectile dysfunction hesitancy/ dribbling urine retention none of these

Endocrine:

- cold intolerance excessive hunger goiter unusual hair growth
 diabetes excessive thirst hair loss voice changes
 excessive appetite abnormal frequency of urination heat intolerance none of these

Skin:

- changes in nail texture hair loss itching skin lesions / ulcers
 changes in skin color hives paresthesias varicosities
 hair growth history of skin disorders rash none of these

Nervous System:

- dizziness limb weakness numbness slurred speech tremor
- facial weakness loss of consciousness seizures stress unsteadiness of gait/
loss of balance
- headache loss of memory sleep disturbance strokes none of these

Psychologic:

- anhedonia behavioral change convulsions memory loss
- anxiety bi-polar disorder depression mood change
- loss or change in appetite confusion insomnia none of these

Allergy:

- anaphalaxis itching chronic nasal congestion sneezing
- food intolerance acute nasal congestion rash none of these

Hematologic:

- anemia blood clotting bruising easily lymph node swelling
- bleeding blood transfusion fatigue none of these

PAST HEALTH HISTORY - Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

X-rays:

Have you had x-rays taken in the last 2 years? If Yes, what office and body part? _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you taken?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you taken?

Childhood Illness (es): LIST all health conditions.

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD cystic kidney disease hypertension psychiatric problems
- alzheimers depression influenzal pneumonia scoliosis

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental sugery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

I... am currently pregnant am NOT currently pregnant

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

father	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
mother	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
son (s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
daughter(s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
brother(s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
sister(s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____

Social History: Mark all that apply below.

Alcohol: do not drink alcohol social consumption only drink regularly, quantity of ___glasses per ___

My Dietary Intake consists mainly of the following: (mark all that apply)

- | | | | | |
|-------------------------------------|---|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> high fat | <input type="checkbox"/> high salt | <input type="checkbox"/> low fiber | <input type="checkbox"/> low sugar | <input type="checkbox"/> low salt |
| <input type="checkbox"/> high fiber | <input type="checkbox"/> low carbohydrate | | | |

Tobacco: Do not use tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking

Smoke: # ___ per Day Week Month; Chew: # _____cans per Day Week Year

Care Choices: Patients come to this office for a variety of reasons.

Crisis/Relief Care: symptomatic pain relief (patch-up care). It corrects the most recent layer of spinal or neurological damage.

Reconstructive/Corrective Care: cause of problem corrected as well as symptomatic relief (fix-up care). Concerned with corrected years of damage that occurred when there were few symptoms

Wellness/Maintenance Care: for relief and spinal correction in addition to looking forward to maintaining heightened state of wellness and vitality.

Please choose type of care that best fits your health and life style goals.

_ Relief care _ Corrective Care _ Wellness care _

Insurance Information:

Who Is Responsible For Your Bill? YOU and... (mark appropriate box(es)) Myself ONLY

Spouse Medicare Insurance AND myself Other (be specific): _____

Policy Holder's Name: _____ **Primary Care Physician:** _____

Are we coordinating care with your physician?:

I would like a copy of my records sent to my physician YES NO

(circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other
Name: _____

Clinic's Name and Location _____

Financial Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Whole Life Chiropractic, PA will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Whole Life Chiropractic, PA will be credited to my account upon receipt. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me the doctor. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card listed below. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If payment hasn't been received in 10 days from terminating care, I authorize deduction from my credit card.

MasterCard/Visa Account #: ***Please have available when checking in at front desk.***

Informed Consent:

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 patient named below, for whom I am legally responsible) by Dr. Murphy and/or other licensed doctors of chiropractic who now or in the future work at Whole Life Chiropractic, PA.

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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the 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 Print Name: _____ **Patient's Signature:** _____ **Date:** _____

Consent to treat a Minor: _____

Guardian or Spouse's Signature of Authorizing Care: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient's Signature: _____ **Date:** _____