EUPHORIC HEALING
Chiropractic Health Center

INITIAL HEALTH STATUS

E-mail: _____

Patient Name: _____ Birthdate: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____ Driver Lic. #: _____

Occupation: _____ Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name: _____ Health Plan: _____

Subscriber ID #: _____ Group #: _____ Spouse Name: _____

Spouse Employer: _____ City: _____ State: _____ Zip: _____

Your Present Weight: _____ Height: _____ (Females) Possibility of current pregnancy? Y / N

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

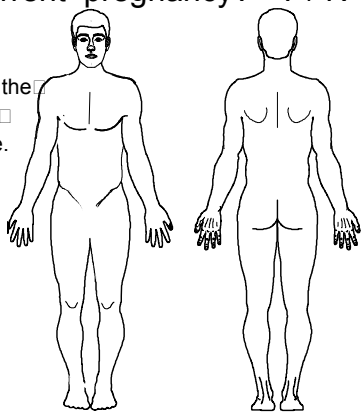
_____

How did you hear about us? _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Mark an X on the picture where symptoms are.



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%

Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that 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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

HEALTH QUESTIONNAIRE

Name of Primary Care Doctor (M.D. or D.O.) _____

Phone _____ City _____

If you have had any of the following within the last 5 years,
give an approximate date and the result:

Lab work (Cholesterol, Diabetes, etc...) _____

Diagnostic studies (MRI, Bone scan, Nerve conduction, etc...) _____

Scopes (Colonoscopy, Sigmoidoscopy, etc...) _____

Do you take any supplements (Vitamin, Minerals, Glucosamine, etc...)? [ ]Yes [ ]No
if so, which ones?

Do you have any foot, arch or heel pain? [ ]Yes [ ]No

Do you have any other extremity pain (knee, wrist, elbow, etc...)? [ ]Yes [ ]No

If "Yes", explain:

Do have any recurring numbess or tingling? [ ]Yes [ ]No

Do you have vertigo or Meniere's? [ ]Yes [ ]No

Would you like to ask any specific questions before the exam begins? (list them here)

May we contact your primary care doctor regarding your healthcare and/or request
your pertinent records? [ ]Yes [ ]No

Signature: _____ Date: _____

A. Treatment Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient 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 work at the clinic or office listed below 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 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 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 Signature _____ Date _____

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B. Consent to Treat a Minor- IF PATIENT IS NOT A MINOR, SKIP TO SECION C.

The information I have given to this office pertaining to _____
(Minor)
is truthful and complete to the best of my knowledge. I authorize the doctors and staff of Blossom Hill Chiropractic to administer such procedures and treatment as described above as they deem necessary to my (son),(daughter),(ward in my legal custody) The doctors have no implied guarantee of cure.

Parent or Guardian's Signature _____ Date _____

Relationship to Minor Child _____

Witnessed By _____ Date _____

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C. Assignment of Benefits

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office above as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient Signature_____ Date _____