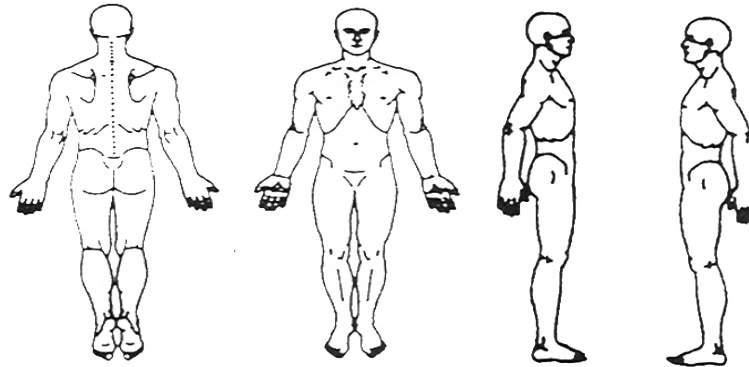


BY USING THE KEY BELOW, INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING THE FOLLOWING SYMPTOMS:
 # = NUMBNESS X = BURNING / = STABBING 0 = PINS & NEEDLES + = DULL ACHE



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

- 0 NO PAIN
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 UNBEARABLE

DESCRIBE YOUR SYMPTOMS:

WHEN DID YOUR SYMPTOMS START?

HOW DID YOUR SYMPTOMS BEGIN? (IF THERE WAS AN ACCIDENT, INJURY OR FALL, PLEASE DESCRIBE.)

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- CONSTANTLY (76%-100% OF THE DAY)
 FREQUENTLY (51%-75% OF THE DAY)
 OCCASIONALLY (26%-50% OF THE DAY)
 INTERMITTENTLY (0%-25% OF THE DAY)

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- DULL
 SHARP
 SHARP WITH MOVEMENT
 THROBBING
 BURNING
 DEEP
 ACHING
 TINGLING
 STABBING
 CRAMPING
 PINPRICK
 NUMBNESS
 RADIATING (WHERE ?) _____

HOW ARE YOUR SYMPTOMS CHANGING?
 GETTING BETTER
 NOT CHANGING
 GETTING WORSE

ARE YOUR SYMPTOMS:

- THE SAME ALL THE TIME
 WORSE — IN THE MORNING
 BY MIDDAY
 AT THE END OF THE DAY
 AT NIGHT
 THROUGHOUT THE DAY
 AT NIGHT WITH PAIN
 BETTER — IN THE MORNING
 BY MIDDAY
 AT THE END OF THE DAY
 AT NIGHT
 THROUGHOUT THE DAY
 AT NIGHT WITH PAIN

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?

- SITTING
 STANDING
 WALKING
 BENDING
 STOOPING
 LIFTING
 SLEEPING
 SNEEZING
 COUGHING
 STRAINING
 REACHING
 TWISTING
 LOOKING UP
 LOOKING DOWN
 MOVEMENT
 REST
 LYING SUPINE
 DRIVING
 TYPING
 SCOOPING
 HOUSEHOLD CHORES
 EXERCISE
 STAIR STEPPING
 OTHER: _____

WHAT RELIEVES YOUR SYMPTOMS?

- SITTING
 STANDING
 LYING DOWN
 LEANING AGAINST A SUPPORT
 NO MOVEMENT OCCURS
 MOVEMENT OCCURS
 HEAT IS APPLIED
 ICE IS APPLIED
 ANALGESIC TOPICAL PAIN RELIEF GEL IS APPLIED
 IBUPROFEN IS TAKEN
 MEDICATION IS USED
 OTHER: _____
 REST OCCURS
 STRETCHING/EXERCISE IS USED
 ADJUSTMENTS ARE PROVIDED

SINCE YOUR COMPLAINT STARTED, HOW MUCH HAS PAIN INTERFERED WITH YOUR NORMAL WORK (INCLUDING BOTH WORK OUTSIDE THE HOME AND HOUSEWORK):

- ALL THE TIME
 MOST OF THE TIME
 SOME OF THE TIME
 A LITTLE OF THE TIME
 NONE OF THE TIME

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS...

- EXCELLENT
 VERY GOOD
 GOOD
 FAIR
 POOR

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? (IF YES WHO AND DATE OF LAST VISIT) _____

WHO HAVE YOU SEEN FOR YOUR CURRENT COMPLAINT?

NO ONE

CHIROPRACTOR (LIST NAME(S) AND TREATMENT RECEIVED) _____

MEDICAL DOCTOR (LIST NAME(S) AND TREATMENT RECEIVED) _____

ORTHOPEDIC/NEUROSURGEON (LIST NAME(S) AND TREATMENT RECEIVED) _____

PHYSICAL THERAPIST (LIST NAME(S) AND TREATMENT RECEIVED) _____

OTHER (LIST NAME(S) AND TREATMENT RECEIVED) _____

WHAT TESTS HAVE YOU HAD FOR YOUR SYMPTOMS? NONE

X-RAYS: WHEN? _____ CT SCAN : WHEN? _____

MRI: WHEN? _____ OTHER: WHEN? _____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO IF YES, WHEN? _____

IF YOU HAVE SOUGHT TREATMENT IN THE PAST FOR THE SAME OR SIMILAR SYMPTOMS, WHO DID YOU SEE?

THIS OFFICE OTHER CHIROPRACTOR MEDICAL DOCTOR PHYSICAL THERAPIST

OTHER _____

IF YOU ARE EXPERIENCING HEADACHES, PLEASE FILL OUT THIS SECTION.

WHERE IS THE PAIN ASSOCIATED WITH YOUR HEADACHES LOCATED?

	RIGHT SIDE	LEFT SIDE
SIDE OF HEAD		
BEHIND EYE		
FRONTAL		
BASE OF SKULL		
JAW JOINT		

ON WHAT DATE DID YOUR HEADACHES BEGIN?
DATE: / / SAME AS NECK/BACK COMPLAINTS

WHAT IS THE INTENSITY OF YOUR HEADACHES ?

1 2 3 4 5 6 7 8 9 10
NO PAIN WORST PAIN POSSIBLE

WHAT DESCRIBES YOUR PAIN?

DULL SHARP ACHING DEEP

STABBING BURNING

THROBBING/PULSATING VICE-LIKE OTHER _____

WHEN DO YOUR HEADACHES USUALLY START?

WAKING IN MORNING DURING EVENING

AT MID-DAY CONSTANT

WHAT SEEMS TO BRING ON YOUR HEADACHES?

PHYSICAL ACTIVITY CAFFEINE

EXCESSIVE STRESS CERTAIN FOODS

ALCOHOL MENSTRUAL PERIOD

OTHER

HOW OFTEN DO THEY OCCUR?
_____X/WEEK _____X/MONTH

HOW LONG DO YOUR HEADACHES LAST?

< 1 HR 1-3 HRS >3 HRS ALL HRS

SEVERAL HOURS OTHER

DO YOUR HEADACHES WAKE YOU? YES NO

DO THE FOLLOWING OCCUR WITH YOUR HEADACHES?

NAUSEA/VOMITING LIGHT/SOUND SENSITIVE

WEAKNESS VISION PROBLEMS

DIZZINESS TREMOR

OTHER _____

WHAT MAKES YOUR HEADACHE BETTER?

NOTHING REST

LYING DOWN ICE/COLD PACKS

MASSAGE STANDING

NSAIDS (ASPIRIN, TYLENOL) OTHER

MEDICAL CONDITIONS	
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> CANCER TYPE: _____ _____	<input type="checkbox"/> PSYCHIATRIC ILLNESS
<input type="checkbox"/> DIABETES	<input type="checkbox"/> SKIN DISORDER
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> STROKE

SURGERIES	
<input type="checkbox"/> APPENDECTOMY	<input type="checkbox"/> JOINT REPLACEMENT
<input type="checkbox"/> CARDIOVASCULAR PROCEDURE	<input type="checkbox"/> CERVICAL DISC PROCEDURE
<input type="checkbox"/> LAMINECTOMIES	<input type="checkbox"/> HYSTERECTOMY
<input type="checkbox"/> RADICAL PROSTATECTOMY	<input type="checkbox"/> TRANSURETHRAL PROSTATE SURGERY
<input type="checkbox"/> OTHER (DESCRIBE): _____	

ALLERGIES	
<input type="checkbox"/> EGGS	<input type="checkbox"/> SOY
<input type="checkbox"/> FISH AND SHELLFISH	<input type="checkbox"/> SULFITES
<input type="checkbox"/> MILK OR LACTOSE	<input type="checkbox"/> WHEAT/GLUTEN
<input type="checkbox"/> PEANUT	<input type="checkbox"/> OTHER: _____

SOCIAL HISTORY	
<input type="checkbox"/> CAFFEINE USED OCCASIONALLY	<input type="checkbox"/> CAFFEINE USED OFTEN
<input type="checkbox"/> CHEW TOBACCO OCCASIONALLY	<input type="checkbox"/> CHEW TOBACCO OFTEN
<input type="checkbox"/> DRINK ALCOHOL OCCASIONALLY	<input type="checkbox"/> DRINK ALCOHOL OFTEN
<input type="checkbox"/> EXERCISE NOT AT ALL	<input type="checkbox"/> EXERCISE OCCASIONALLY
<input type="checkbox"/> EXERCISE OFTEN	<input type="checkbox"/> EXPERIENCE STRESS OCCASIONALLY
<input type="checkbox"/> EXPERIENCE STRESS OFTEN	<input type="checkbox"/> SMOKE 1 PACK OR LESS PER DAY
<input type="checkbox"/> SMOKE MORE THAN 1 PACK A DAY	<input type="checkbox"/> WEAR SEAT BELTS ALWAYS
<input type="checkbox"/> WEAR SEAT BELTS NEVER	<input type="checkbox"/> WEAR SEAT BELTS USUALLY

SUBSTANCE USE	
<input type="checkbox"/> ALCOHOL (PAST)	<input type="checkbox"/> ALCOHOL (PRESENT)
<input type="checkbox"/> AMPHETAMINES (PAST)	<input type="checkbox"/> AMPHETAMINES (PRESENT)
<input type="checkbox"/> BARBITUATES (PAST)	<input type="checkbox"/> BARBITUATES (PRESENT)
<input type="checkbox"/> COCAINE (PAST)	<input type="checkbox"/> COCAINE (PRESENT)
<input type="checkbox"/> CRYSTAL METH (PAST)	<input type="checkbox"/> CRYSTAL METH (PRESENT)
<input type="checkbox"/> HEROINE (PAST)	<input type="checkbox"/> HEROINE (PRESENT)
<input type="checkbox"/> MARIJUANA (PAST)	<input type="checkbox"/> MARIJUANA (PRESENT)

OCCUPATIONAL ACTIVITIES	
<input type="checkbox"/> BUSINESS OWNER	<input type="checkbox"/> COMPUTER/ADMINISTRATIVE
<input type="checkbox"/> EXECUTIVE/LEGAL	<input type="checkbox"/> FOOD SERVICES
<input type="checkbox"/> HEALTHCARE/HOMESERVICES	<input type="checkbox"/> CONSTRUCTION/LABORER
<input type="checkbox"/> HOUSHOLD	<input type="checkbox"/> OTHER: _____

RECREATIONAL ACTIVITIES	
<input type="checkbox"/> BACKPACKING	<input type="checkbox"/> BOATING
<input type="checkbox"/> GOLF	<input type="checkbox"/> RUNNING
<input type="checkbox"/> SOCCER	<input type="checkbox"/> TENNIS
<input type="checkbox"/> WEIGHT LIFTING	<input type="checkbox"/> FOOTBALL
<input type="checkbox"/> BIKING	<input type="checkbox"/> SKIING
<input type="checkbox"/> RACKET BALL	<input type="checkbox"/> WALKING
<input type="checkbox"/> SWIMMING	<input type="checkbox"/> OTHER: _____

WOMEN ONLY	
TO YOUR KNOWLEDGE, ARE YOU PREGNANT?	
IF PREGNANT IN PAST, WERE PREGNANCIES NORMAL?	
ARE YOU SEEING AN OB-GYN REGULARLY?	
# OF BIRTHS:	DATE OF LAST EXAM:
PHYSICIAN'S NAME & ADDRESS:	

HAVE YOU EVER HAD A SERIOUS ACCIDENT/INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO (LIST, DATE, AND DESCRIBE)
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO (PLEASE LIST)
ARE YOU CURRENTLY TAKING ANY VITAMINS, MINERALS, OR HERBS? <input type="checkbox"/> YES <input type="checkbox"/> NO (PLEASE LIST)
ARE YOU ALLERGIC TO ANY MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO (LIST MEDICATIONS)

REVIEW OF SYSTEMS

HAVE YOU HAD TROUBLE WITH ANY OF THE FOLLOWING:

CARDIOVASCULAR

- POOR CIRCULATION
- HIGH BLOOD PRESSURE
- AORTIC ANEURYSM
- HEART DISEASE
- HEART ATTACK
- CHEST PAIN
- HIGH CHOLESTEROL
- PACE MAKER
- JAW PAIN
- IRREGULAR HEARTBEAT
- SWELLING OF LEGS

PRESENT	PAST

EARS/ NOSE/ THROAT

- DIZZINESS
- HEARING LOSS
- SINUS INFECTION
- NOSEBLEED
- SORE THROAT
- DIFFICULTY SWALLOWING
- BLEEDING GUMS

PRESENT	PAST

MUSCULOSKELETAL

- GOUT
- ARTHRITIS
- JOINT STIFFNESS
- MUSCLE WEAKNESS
- OSTEOPOROSIS
- BROKEN BONES
- JOINTS REPLACED

PRESENT	PAST

EYES

- GLAUCOMA
- DOUBLE VISION
- BLURRED VISION

PRESENT	PAST

ENDOCRINE

- THYROID DISEASE
- DIABETES
- HAIR LOSS
- MENOPAUSAL
- MENSTRUAL PROBLEMS

PRESENT	PAST

GENITOURINARY

- KIDNEY DISEASE
- LOWER SIDE PAIN
- BURNING URINATION
- FREQUENT URINATION
- BLOOD IN URINE
- KIDNEY STONE

PRESENT	PAST

INTEGUMENTARY

- SKIN ULCERS
- SKIN DISEASE
- ECZEMA
- PSORIASIS
- RASHES

PRESENT	PAST

PSYCHIATRIC

- DEPRESSION
- ANXIETY DISORDER
- UNUSUAL STRESS

PRESENT	PAST

HEMATOLOGIC/ LYMPHATIC

- HEPATITIS
- BLOOD CLOTS
- CANCER
- EASY BRUISING
- EASY BLEEDING
- FEVERS/CHILLS/SWEATS

PRESENT	PAST

ALLERGIC/ IMMUNOLOGIC

- HIVES
- IMMUNE DISORDER
- HIV/AIDS
- ALLERGY SHOTS
- ALLERGY MEDS
- CORTISONE USE

PRESENT	PAST

CONSTITUTIONAL

- WEIGHT LOSS/GAIN
- ENERGY LEVEL PROBLEM
- DIFFICULTY SLEEPING

PRESENT	PAST

RESPIRATORY

- ASTHMA
- TUBERCULOSIS
- SHORTNESS OF BREATH
- EMPHYSEMA
- COLD/FLU
- COUGH/WHEEZING
- BRONCHITIS

PRESENT	PAST

GASTROINTESTINAL

- GALLBLADDER PROBLEMS
- BOWEL PROBLEMS
- CONSTIPATION
- LIVER PROBLEMS
- ULCERS
- DIARRHEA
- NAUSEA/VOMITING
- BLOODY STOOLS
- POOR APPETITE

PRESENT	PAST

NEUROLOGIC

- STROKE
- SEIZURES
- HEAD INJURY
- BRAIN ANEURYSM
- NUMBNESS
- SEVERE HEADACHES
- PINCHED NERVES
- PARKINSONS DISEASE
- CARPAL TUNNEL
- SPINNING/BALANCE

PRESENT	PAST

RELEASE OF INFORMATION

I _____ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, Inc. to share any information related to my care, account and services to the following people:

Form with fields for NAME, RELATIONSHIP, ADDRESS, CITY, STATE, ZIP, and PHONE for two individuals.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understand both the objective and the method that will be able to attain it.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities.

- You may request restrictions on your disclosures.
You may inspect and receive copies of your records within 30 days with a request.
You may request to view changes to your records.
In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Form with fields for SIGNATURE, WITNESS SIGNATURE, GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE, and DATE.

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

- PATIENT SPOUSE PARENT WORKERS COMP AUTO INSURANCE MEDICARE HEALTH INSURANCE