Joint Effort Chiropractic

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The following is a health history questionnaire. All information will be kept confidential.

Name:_____ SS#_____

Address_____ Date of birth_____

_____ Sex: M F

Phone- Home: _____ Business: _____ Cell: _____

Email address: _____ Height _____ Weight _____lbs.

Occupation: _____ Employer: _____

Primary care physician (name/location):_____ Last examination:_____

Emergency contact (name/number): _____

How did you hear about the office? _____

Marital status: S M W D Number of children:_____Have you ever been treated by a chiropractor? yes □ no □

Briefly describe your present complaint(s) or injury:

_____

_____

Onset date of injury:_____ Have you had this before? yes □ no □ If yes, when?_____

Is your condition getting: better □ worse □ staying the same □

The pain is: Constant □ Intermittent □

What aggravates your condition? _____

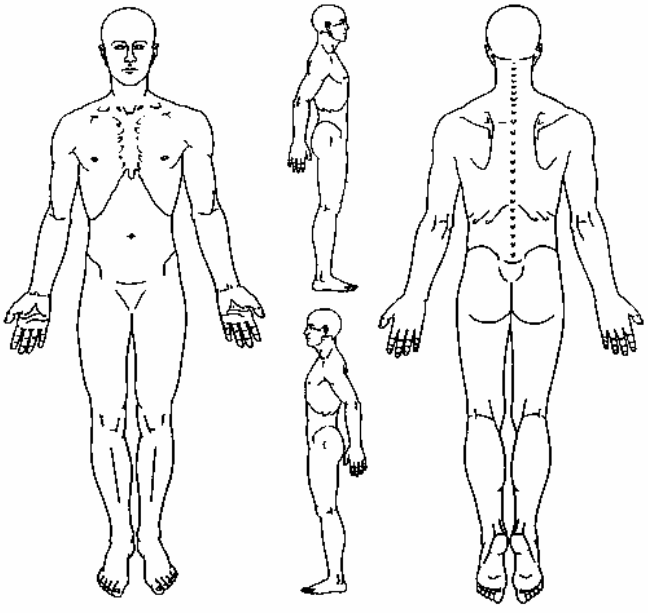
What relieves your condition? _____

Is there a time of day when your condition is worse? Morning □ Afternoon □ Evening □ During the night □

How would you describe your symptoms? (you may check more than one)

Sharp/shooting □ Burning □ Numbness/tingling □ Dull/achy □ Throbbing □ Clicking □ Weakness □

On the diagram below please indicate (with the appropriate letter) where you are experiencing pain.



A = Aching **B** = Burning **N** = Numbness
S = Stabbing **T** = Tingling

Please circle your level of pain below

Pain Currently

1 2 3 4 5 6 7 8 9 10

Pain at its worst

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any of the following (if yes, describe):

Fatigue	no☐	yes☐ _____
Chills	no☐	yes☐ _____
Unexplained weight loss	no☐	yes☐ _____
Night sweats	no☐	yes☐ _____
Pain at night	no☐	yes☐ _____
Fever	no☐	yes☐ _____
Swollen glands	no☐	yes☐ _____
Dizziness / vertigo	no☐	yes☐ _____
Blurred or double vision	no☐	yes☐ _____
Hearing loss	no☐	yes☐ _____
Fainting	no☐	yes☐ _____
Nausea or vomiting	no☐	yes☐ _____
Loss of bowel / bladder control	no☐	yes☐ _____
Abdominal pain	no☐	yes☐ _____
Chest pain	no☐	yes☐ _____
Shortness of breath	no☐	yes☐ _____
Chronic cough	no☐	yes☐ _____
Heartburn/GERD	no☐	yes☐ _____

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None

Name and address of other doctor(s) who have treated your condition:

_____

Date of last: Physical exam_____ Spinal x-ray_____ Blood test_____ Spinal exam _____ MRI _____ CT _____

Place a mark on "Y" for yes or "N" for no to indicate if you have had any of the following:

AIDS/HIV	☐ Y ☐ N	Chicken Pox	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Rheumatoid Arthritis	☐ Y ☐ N
Alcoholism	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Measles	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Allergy Shots	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Migraines	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Anemia	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Miscarriage	☐ Y ☐ N	Stroke	☐ Y ☐ N
Anorexia	☐ Y ☐ N	Fractures	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N	Suicide Attempt	☐ Y ☐ N
Appendicitis	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Multiple Sclerosis	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Asthma	☐ Y ☐ N	Goiter	☐ Y ☐ N	Mumps	☐ Y ☐ N	Tonsilitis	☐ Y ☐ N
Bleeding Disorders	☐ Y ☐ N	Gonorrhea	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Breast Lump	☐ Y ☐ N	Gout	☐ Y ☐ N	Pacemaker	☐ Y ☐ N	Tumor's, Growths	☐ Y ☐ N
Bronchitis	☐ Y ☐ N	Heart Disease	☐ Y ☐ N	Parkinson's Disease	☐ Y ☐ N	Typhoid Fever	☐ Y ☐ N
Bulimia	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Pinched Nerve	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Cancer	☐ Y ☐ N	Hernia	☐ Y ☐ N	Pneumonia	☐ Y ☐ N	Vaginal Infections	☐ Y ☐ N
Cataracts	☐ Y ☐ N	Herniated Disc	☐ Y ☐ N	Polio	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Chemical Dependency	☐ Y ☐ N	Herpes	☐ Y ☐ N	Prostate Problems	☐ Y ☐ N	Whooping Cough	☐ Y ☐ N
		High Cholesterol	☐ Y ☐ N	Prosthesis	☐ Y ☐ N	Other_____	
		Kidney Disease	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs per day _____
☐ Alcohol Drinks per week _____
☐ Coffee/ Caffeine Drinks Cups per day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Injuries / Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Surgeries		

MEDICATIONS

_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

NUTRITIONAL SUPPLEMENTS

_____
_____
_____
_____
_____

Do you or an immediate family member have a history of any of the following? If yes, describe.

Cancer	no☐	yes☐	_____
Heart attack	no☐	yes☐	_____
Heart disease	no☐	yes☐	_____
Stroke	no☐	yes☐	_____
Diabetes	no☐	yes☐	_____
Arthritis	no☐	yes☐	_____
Thyroid problems	no☐	yes☐	_____

Informed Consent:

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures performed by Dr. Donath. I understand that, as in the practice of traditional medicine, in the practice of chiropractic there are some risks to treatment including but not limited to disc injury, fractures/joint injury, and stroke. The possibility of such injuries are extremely rare. I do not expect Dr. Donath to be able to anticipate all risks and complications and I wish to rely on the doctor's judgment during the course of the procedure which the doctor feels, at the time, based upon the facts then known, is in my best interest.

I have read and understand the above consent. I intend this consent to apply to all my present and future chiropractic care with Dr. Donath.

Patient's signature: _____ Date: _____