Yachter Family Chiropractic Center
Patient History

(**Please print**, all information is confidential)

Name: ____Referred by: ____________________

Address: __________________________________City:_____________ State: _______Zip:______

Home Ph: ______________ Work P: _______________Cell Ph: ________________________________

Other Ph: ______________E-mail: ____

Sex: M F Marital Status: ______ DOB: __________ Age: _____ # of Children: ____________________

Occupation: _______________________________ Employer: ________________________________

Do you have insurance? Y or N **(If yes, please give the front desk your card to copy)**

FOR PRESENT CONDITIONS MARK AN "X", PAST CONDITIONS MARK AN "O"

______Fractured bones
______Auto accidents
___0-1 yrs ago
___1-5 yrs ago
___more than 5
______Other accidents/falls
______Back curvature
______Arthritis
______Diabetes
______Swollen/Painful joints
______Convulsions/epilepsy
______Skin problems
______Cancer
______Frequent colds/flu
______Depressed
______Irritable
______Anemia
______Tremors
______Allergies

______Sinus problems
______Eating disorder
______Trouble sleeping
______Trouble concentrating
______Learning disability
______Mood changes
______Headache
______Pain/Stiff neck R L
______Numbness/Ting./Pain Arms/Hands/Fingers R L
______Jaw pain/TMJ R L
______Head/Shoulders tired
______Difficulty in excessive (Standing, walking, bending, riding, twisting, lifting, household duties)
______Shoulder pain R L
______Dizziness
______Ringing in ears R L

______Hearing loss R L
______Fainting
______Loss of balance
______Blurred vision R L
______Double vision R L
______Upper back pain/stiff.
______Mid back pain/stiff.
______Low back pain/stiff.
______Numbness, tingling or pain in buttocks, thighs, legs, feet, toes
______Pain w/ cough/sneeze
______Hip pain R L
______Foot trouble
______Chest pain
______Asthma
______Lung problems
______Difficulty breathing
______Heart problems

______Stroke
______High/Low blood press.
______Varicose veins
______Liver trouble
______Gall bladder trouble
______Digestive problems
______Heartburn
______Ulcers
______Diarrhea/Constipation
______Colon trouble
______Hemorrhoids
______Prostate problems
______Impotence
______Kidney trouble
______Menstrual problems
______Menopausal problems
______Pregnant (now)
______Bed wetting
______Ear infection
______AIDS/HIV

List all surgeries: ____
____

What medications (even non prescription) are you taking? ______________________________
____

Is your visit due to an accident, injury or trauma? Y_____N_____ If so, was it AUTO________ Work________
Describe the events of the accident: ____
____

Have you seen any other health care providers for this accident, injury or trauma? Y___N___ Who? _________
What treatment did you receive? ____

CONSULTATION/HISTORY REVIEW:

Vertebral Subluxation Interview:

Are you aware that every symptom or condition, which you have listed from the front page, is typically the result of interference in your nerve system or from Subluxation? **Y** ____________**N** _____________
Symptoms and pain are the two most common results of Subluxation. Symptoms and pain are usually signals to let the body know something is wrong.

1. Which problem or condition you listed on the front page is the worst? ____________________________
   Is this the first time or have you experienced this problem in the past? ____________________________

2. How long had this condition been a problem? ____

3. What have you done to relieve your pain and suffering? _______________________________________

4. Subluxations can cause different irritation/sensation to the nerve fibers. Describe how your pain feels. (I.e. sharp, stabbing, numbness, tingling, achy, throbbing etc.)___________________________________

5. Subluxations often put pressure on the spinal cord. Symptoms may come and go over time. Is your condition: **CONSTANT OR INTERMITTENT** (circle one)

6. Pressure on the spinal cord can vary throughout the day, is your condition worse in the:
   AM PM CONSTANT (circle one)

7. Does your pain ever radiate into your arms or legs or is it local to one area? **ARMS R L LEGS R L STAYS IN ONE AREA** (circle one)

8. Is there anything else you think the doctor should know concerning your condition? YES____NO____
   ____

Thank you for your input. This information will be very beneficial in helping the doctor to understand your health history, while being very specific and respectful of your time. We look forward to helping you discover the root cause of your problem or condition.

YACHTER FAMILY CHIROPRACTIC CENTER

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective.

Chiropractic had only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappoint.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebralsubluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression to the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

In case of emergency, notify ______________________Phone #_______________________

I, ____have read and fully understand the
(Print _Name)
above statements. I therefore accept chiropractic care on that basis.

____ ____________________
(Signature) (Date)

COMPLETE IF THE PATIENT IS A MINOR CHILD:
Child's name: ____

I____________________________________, being the parent or legal guardian of the
(Parent/Guardian Print _Name)
aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ________________________________
(Parent's/Guardian's Signature) (Date)