

Dr. Leslie Dreifus & Dr. Robin Wieder

Chiropractors

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Date: _____

Patient History

Name _____ Sex: M ___ F ___ Birthdate _____
 Address _____ City _____ State _____ Zip _____
 H. Phone# _____ Cell #: _____ W. Phone# _____ Email: _____
 Referred by _____ Social Security # _____ Occupation: _____
 Employer/School _____ Address: _____
 Marital Status S M D W Spouse Name _____ # of children _____
 Emergency Contact: _____ Relationship to patient: _____
 Cell.Ph# _____ Home Ph# _____ Work # _____
 Primary Health Insurance: _____ Name of Insured _____ ID# _____
 Secondary Health Insurance: _____ Name of Insured _____ ID# _____
 Have you ever received Chiropractic Care? Yes ___ No ___

1. IMPORTANT: EXPLAIN WHAT HURTS AND YOUR SYMPTOMS (Your Present Complaint/Reason for Seeking Care):

Car accident? Y ___ N ___ Work Accident? Y ___ N ___

Pain or Problem started on _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Where? _____

Are you experiencing numbness or tingling in any area of your body? Where? _____

Since it began, is it: Same Better Worst

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with Work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Please circle for each of the following:

2. Your Health History

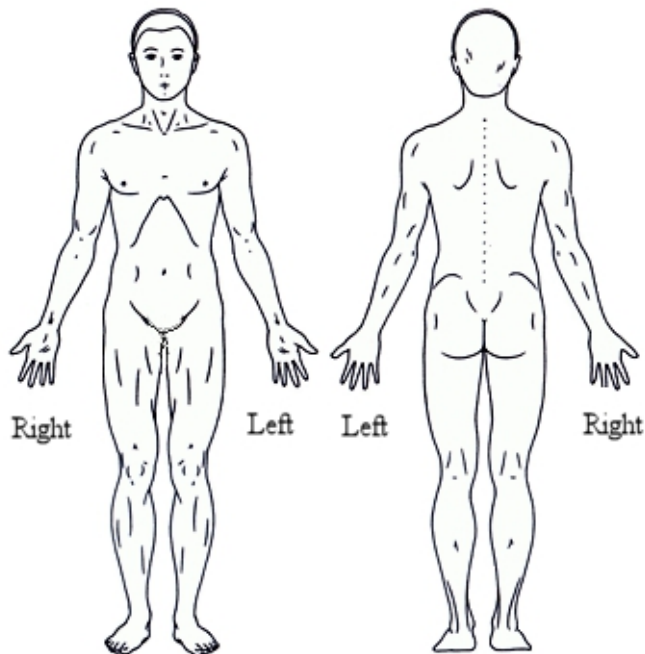
	Patient Comment If answer is Yes	Chiropractor's Comments
Childhood illnesses?	Y N _____	_____
Drugs, prescription, OTC, recreational?	Y N _____	_____
Surgery?	Y N _____	_____
Hospitalizations?	Y N _____	_____
Sports or other physical activities	Y N _____	_____
Injuries during sports?	Y N _____	_____
Auto accidents?	Y N _____	_____
Did you have other traumas?	Y N _____	_____
Did you ever break any bones?	Y N _____	_____

3. Your Current Health Habits:

Did/do you smoke?	Y N _____	_____
Did/do you drink alcohol?	Y N _____	_____
Diet, do you eat healthy foods?	Y N _____	_____
Have you been in accidents/trauma?	Y N _____	_____
Have you had surgery?	Y N _____	_____
Drugs, prescription, OTC, recreational?	Y N _____	_____
Dental problems?	Y N _____	_____
Eye problems?	Y N _____	_____
Hearing problems?	Y N _____	_____
Exercise regularly?	Y N _____	_____
Did/do you have occupational stress?	Y N _____	_____
Drive? Daily time spent driving	Y N _____	_____
Physical stress?	Y N _____	_____
Emotional/Mental stress?	Y N _____	_____
Hobbies/Sports injuries?	Y N _____	_____
Do you sleep well, hours of sleep?	Y N _____	_____
Sleeping posture? O side O stomach O back	_____	_____

Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Using the symbols below, mark on the pictures where you feel pain.



- Numbness = = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing / / /
- Pins, Needles + + +
- Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menopause |

Are you under medical care for any condition? _____

What Medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Females Only – Date last Menstrual Period began on _____ Are you possibly Pregnant? _____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Assign and Release:

I hereby authorize my insurance benefits to be paid to this practitioner. I also authorize the release of any information required. I hereby give permission for insurance payments to be made directly to the above provider. If I fail to provide the appropriate insurance information, referrals if required, and information requested to the above office, I will be held responsible and agree to pay for all fees incurred by this office. I hereby acknowledge that I have received and reviewed the Privacy Notice posted in this office and all of my questions have been answered in the language that I can understand. I consent to the uses and disclosures described in the Privacy Notice.

Consent to Treat:

Diagnosis, prognosis & treatment protocols and effects and risks thereof have been described and I understand and am informed of such information. I hereby give consent to such treatment as described by the doctor. I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment. This level of risk is most often very minimal and rare. These rare cases may include but not be limited to strain/sprain injuries, disc irritation, skin irritation, and fracture. Health history, physical examination provided prior to care to be discussed with doctor. Chiropractic care may include spinal manipulation, the use of modalities such as ultrasound, electric muscle stimulation, supportive/therapeutic taping/strapping, manual massage/trigger point therapy, cupping & rehabilitative care such as exercise. I intend this consent to apply to all my present and future chiropractic care.

Patient/Parent or Guardian: _____ Date: _____ Dr's signature: _____