



Helping You Reach Optimal Health

CHIROPRACTIC CASE HISTORY

Date _____ Name _____ Sex M__ F__ Marital Status: S M D (other)
Address _____ City _____ State _____ Zip _____
H.Phone (____) _____ Cell (____) _____ Email _____
Date of Birth _____ Age _____ Referred by _____
Occupation _____ Employer _____ Employer Phone _____
In Case of Emergency: (____) _____ Name: _____ Relationship _____
Have you ever received Chiropractic Care? Yes No If yes when? _____

1. Primary reasons for seeking chiropractic care:

Primary Reason: _____ Secondary Reason _____

Location of Complaint: _____ Complaint began when and how: _____

The above condition(s) are due to Auto Accident YES NO or Work Related Injury YES NO

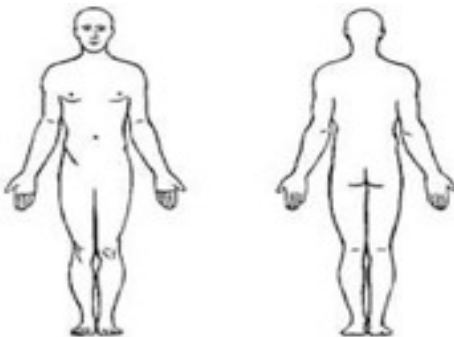
Please circle the Quality of the complaints/pain: dull aching sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel (shoot) to any areas of your body? YES NO Where? _____

Do you have any numbness/tingling in your body? YES NO Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

Shade or mark on the figure your area of pain



- a). How frequent is complaint present, how long does it last? _____
- b). Does anything aggravate the complaint? _____
- c). Does anything make the complaint better? _____
- d). Do you have flat-feet, or pain in your feet? _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

3. Past Health History:

A. Previous illnesses you've had in your life: _____
B. Previous injury or trauma _____

C. Allergies: _____

D. Medications/Vitamins You Are Currently Taking:

| Medication(s) / Vitamin(s) : | Reason for taking |
|------------------------------|-------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

E. Surgeries You Have Had (Females, list pregnancies and outcomes here):

| Date | Type of Surgery |
|-------|-----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Females Only:

What was the date of the beginning of your last menstrual period? _____ **Are you Pregnant now? YES NO**

4. Family Health History:

Associated health problems of relatives (circle):

Mother: Cancer Heart Diabetes Other _____ Father: Cancer Heart Diabetes Other _____

Sibling: Cancer Heart Diabetes Other _____ Sibling: Cancer Heart Diabetes Other _____

5. Social and Occupational History:

Level of Education: () High School () Some College () College Graduate () Post Graduate Studies

Job description: _____

Work schedule: _____

Lifestyle/Exercise Routine (including tobacco and/or drug use, diet): _____

COMPREHENSIVE MEDICAL HISTORY: I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____ Date _____

Review of Systems

| Please Check all conditions you currently have or have had: | | | |
|---|---|--|--|
| General questions | Cardiovascular | Kidneys & Urinary Tract | Musculoskeletal |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Angina | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Brown urine | <input type="checkbox"/> Back pain <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Change in sleep patterns | <input type="checkbox"/> Murmurs | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Gout <input type="checkbox"/> Joint aches |
| <input type="checkbox"/> Change in activity capacity | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Neck Pain <input type="checkbox"/> Tendinitis |
| | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Involuntary urination | <input type="checkbox"/> Abnormal Blood Counts |
| Neurological & Psychiatric | <input type="checkbox"/> Short of breath at night | <input type="checkbox"/> Urinating frequently (day) | <input type="checkbox"/> Blood clots in legs/ lungs |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Urinating frequently (night) | <input type="checkbox"/> Bone marrow biopsy |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Urine hesitancy | <input type="checkbox"/> Easy bleeding |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Weak flow | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Dizziness when standing | <input type="checkbox"/> Frequent bladder infections | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High/low blood pressure | | |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Irregular heart rate | Endocrine | Gastrointestinal |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Purple fingers or lips | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Leg pain that resolves w/ rest | <input type="checkbox"/> Sickle cell | <input type="checkbox"/> Reflux <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Fainting/ dizziness | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Abnormal body hair | <input type="checkbox"/> Ulcers <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Head injuries | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Changes in skin texture | <input type="checkbox"/> Hepatitis <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Blackouts | | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Change in sensation | Respiratory | <input type="checkbox"/> History of Borderline Diabetes | <input type="checkbox"/> Anal fissures |
| <input type="checkbox"/> Localized weakness/ numbness | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Increased loss of hair | <input type="checkbox"/> Black tarry stools |
| | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Vomiting blood |
| Ears, Eyes, Nose, & Throat | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Breathlessness when lying flat | | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prolonged cough | Males Only | <input type="checkbox"/> Problems swallowing |
| <input type="checkbox"/> Polyps | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sterility | <input type="checkbox"/> Intestinal obstruction |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bloody ejaculation | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Inability to complete intercourse | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Lump on testicle | <input type="checkbox"/> Red blood after bowel movements |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Frequent infections(bronchitis) | <input type="checkbox"/> Penile discharge | |
| <input type="checkbox"/> Gum problems | | <input type="checkbox"/> Premature ejaculation | Females Only |
| <input type="checkbox"/> Eye problems | Skin | <input type="checkbox"/> Problems maintaining erection | <input type="checkbox"/> D + C <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Abscess <input type="checkbox"/> Athletes foot | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Hernia <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Glasses/ contacts | <input type="checkbox"/> Acne <input type="checkbox"/> Boils | <input type="checkbox"/> Sores/ warts on penis | <input type="checkbox"/> Abnormal bleeding between cycles |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Hives <input type="checkbox"/> Lumps | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> Ear discharge/ pain | <input type="checkbox"/> Jaundice <input type="checkbox"/> Dandruff | <input type="checkbox"/> Testicular swelling | <input type="checkbox"/> Bleeding after intercourse |
| <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Oily skin <input type="checkbox"/> Rashes | | <input type="checkbox"/> Complications w/ pregnancy |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dry skin <input type="checkbox"/> Psoriasis | Male & Female | <input type="checkbox"/> PMS <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Excessive body odor | <input type="checkbox"/> Painful sexual intercourse | <input type="checkbox"/> Heavy bleeding during cycles |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Loss of sexual interest | <input type="checkbox"/> Discharge from breast |
| | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Unprotected sex | <input type="checkbox"/> Ovarian cyst |
| | <input type="checkbox"/> Nail problems | <input type="checkbox"/> Groin itching | <input type="checkbox"/> Pelvic Inflamm. Disease |
| | <input type="checkbox"/> Moles: irregular new/change | <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Postmenopausal symptoms |
| | | | <input type="checkbox"/> Vaginal discharge |
| | | | <input type="checkbox"/> Vaginal dryness |
| | | | <input type="checkbox"/> Vaginal Warts |

Peters Chiropractic Clinic
Informed Consent to Chiropractic Adjustments and Care

RCW 18.25.005 “Chiropractic” defined

(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care of treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which will- include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedure consistent with this chapter.

RCW 18.25.006 Definitions

(5) “Vertebral Subluxation Complex” means a functional defect or alteration of the biomechanical physiological dynamics in a joint that may cause neuronal disturbances, with or without displacement detectable by x-ray. The effects of the vertebral subluxation complex may include, but are not limited to, any of the following: Fixation, hypo mobility, per articular muscle spasm, edema, or inflammation.

(9) “Chiropractic Adjustment” means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion.

It is not uncommon for some patients to experience some increased discomfort after an adjustment. If that happens, I agree to apply ice on the area and rest. If I am concerned about this discomfort or develop any new symptoms, I may call the office at 210-927-2095. If I am out of town or unable to contact the doctor, I may present myself to the emergency room.

As in all health care, there are some risks to treatment including but not limited to, muscle sprain/strain, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks or complications; however the doctor will do his best to explain the problem.

Based on the facts and findings as presented to the doctor at the time of treatment, I agree to rely on the doctor to exercise judgment which is based on my best interest and well-being during the course of the procedures.

I have read the above consent with the doctor and/or staff as indicated by my signature. I have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature _____

Date _____

Office Policies

Welcome to **Peters Chiropractic Clinic**, where *Helping You Reach Optimal Health* is our mission. We offer 3 primary services:

Chiropractic Care
Nutritional Support
Foot Care (Functional Orthotics)

There is much to learn about these important areas which lead to better health, and focusing on these areas will add life to your years.

Below are our office procedures regarding appointments / walk-in, and payments. Please take the time to read and become acquainted with them.

1. *New Patient Care Services:*

New patient services consist of a consultation, an X-ray of the area of main complaint, an exam, and a chiropractic adjustment in or near the area of pain. To provide the best care, you are required to complete an **Intake Form**. The forms allow the doctor and staff to evaluate your chiropractic needs. X-Ray(s) is/are taken so that the doctor can determine the symptoms of pain. The doctor will provide a verbal report of the X-Ray to you as part of the consultation. After the X-Ray report, the doctor will perform the first adjustment(s) where appropriate to help alleviate your pain. Finally, the doctor will discuss a treatment plan to help restore and align your body toward wellness, and answer any questions.

2. *Follow-up Patient Care Services:*

After initial consultation and depending on the gravity of the condition, you may need to follow up with the doctor. A treatment plan will involve of a number of follow up visits to correct your condition. The doctor will review your plan with you to determine what is best for you. Each patient is different, so not all treatment plans are the same. If you are released from your treatment plan, or have been away longer than 60 days without seeing the doctor, or you have a new pain condition, you will be required to complete a **New Condition Form**. Under this situation, it is possible a new X-ray will be needed of the area to determine the new cause of pain. Procedures explained above in the new patient section will apply.

3. *Office Policy Regarding X-Rays*

All new patients are required to have an X-Ray taken only where your pain originates. The X-Ray(s) is/are good for two years if no new incident occurs to the same area(s). If an established patient has been away longer than 1 year or has a new pain condition, an X-Ray may be required. If you wish to take additional X-Rays, additional fees will apply. If you wish to take your X-Ray to another physician, you must complete a Medical Release Form. To complete this process, we require 48 hours notice.

4. *Patient Payment Policy*

We require 100% payment of all charges due on each visit. We accept Cash, Debit, Visa, MasterCard, Discover, and American Express only.

5. *Our Policy on Health Insurance*

Health insurance is not required to be treated at Peters Chiropractic Clinic. If you wish to submit your services to your healthcare insurance, we can provide you with a receipt for you to submit your treatment claim directly to your insurance.

6. *Office Policy on Appointments & Walk-ins*

In order to better serve our patients, we schedule appointments in advance. Walk-ins are welcome but patients with appointments will have first priority. If you are unable to keep your scheduled appointment, we ask that you cancel it at least 24 hours in advance. If you are running late, please contact us to let us know. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. If you do not contact us as stated above, you will be charge a **\$25 missed appointment fee**. Please help us help others. Our office hours are posted on our website: www.peterschirosoa.com.

I have read the Peters Chiropractic Clinic Policies and I will honor them.

Patient's Signature

Date