# Robinson Chiropractic and Wellness Center

Legal Name:				C	Date:	/	_/
Address:	Cit	ty:		State:	Z	ip:	
Telephone Home: ()	Work: (	)	Cell:	(	_)		
We use text messaging for appointment reminders.	Who is your cell	phone company:					
Email Address:			Social Securit	y Num	ber:		
Preferred Name:		Male	Female	Date	of Birth:	/	/
If you are under 18 years of age, who are your legal p	parents or guard	lian?					
Father/Mother/Guardian:			Phone:	(	_)		
Who do you normally live with (check all that apply):							
Guardian/Foster Parent	Grandparen	t(s) DBrother(s)	)/Sisters(s) 🔲Noi	ne of th	ese		
Marital Status:  Married  Single  Divorced	Widowed						
Spouse's Name: Number	er of children:	Names of ch	ildren:				
Occupation:		Employer:					
Employers Address:			Phone:	(	_)		
Student at				□FUI	L-TIME		RT-TIME
Who should we contact in the event of an emergency	?						
Phone: () Address	s of contact pers	son:					
Have you seen a Chiropractor before? □Yes □N	No If yes, wher	ı?					
What is the reason for your appointment today: $\_$							
Whom may we thank for referring you to our office?							

## YOUR HEALTH HISTORY

Please I check all symptoms you have ever had, even if they do not seem related to your current problem.

	Headaches		Pins and Needles in Legs		Fainting	Neck Pain
	Pins and Needles in arms		Loss of Smell		Back Pain	Loss of Balance
	Dizziness		Buzzing in ears		Ringing in Ears	Nervousness
	Numbness in Fingers		Numbness in Toes		Loss of Taste	Stomach Upset
	Fatigue		Depression		Irritability	Tension
	Sleeping Problems		Neck Stiff		Cold Hands	Cold Feet
	Diarrhea		Constipation		Fever	Hot Flashes
	Cold Sweats		Lights Bother Eyes		Problem Urinating	Heartburn
	Mood Swings		Menstrual Pain		Menstrual Irregularity	Ulcers
Have you had	-	ast?	Yes No If so, when	י? _		 Come and go? □Yes □No
Have you bee	en diagnosed with cancer?		es UNo Year:	Typ	e:	 
Family history: 🗅 Cancer 🛛 Diabetes 🕞 High Blood Pressure 🖓 Cardiovasular Problems/Stroke						
Is your condition or injury due to an accident or work-related cause?   YES   NO						
Please check	ALL that apply:					
Did the condition or injury result from an automobile accident?  YES NO						
Did it result from a work-related accident or cause?   YES   NO Briefly Describe:						

\*\*if you have answered YES to any of the above questions, please see the Front Desk for additional paperwork.\*\*

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? 
YES NO UNCERTAIN
UNCERTAIN

# Robinson Chiropractic and Wellness Center

Do you have health insurance? 🖵 YES 🗖 NO	
Insurance Company:	
Full Name of Policy Holder:	Policy Holder's Date of Birth://
Is the insurance through his/her employer? 🖬 YES 🔲 NO If yes, who is t	the Employer?
Primary Care Physician:	
Phone: () Address:	

It is our office policy that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment.

#### Ehlers Danlos (type IV) Marfan's Disease – Marfan Variant Disorders:

Ehlers-Danlos and Marian's Disease are genetic conditions that have been associated with injuries of the joints, connective tissues and blood vessels of the body. Other known, but yet-to-be named, genetic variants exist and are associated with similar risks. Medical studies have reported that blood vessel injuries of the neck known as cervical arterial dissections may occur spontaneously, with trivial traumas of the spine, in patients with high homocysteine levels, and/or during upper respiratory infections— particularly in these groups of patients. Have you been told that you have a connective tissue disorder? Yes / No

#### Informed Consent Form

What are the common side-effects of chiropractic care? Chiropractic is among the safest health disciplines in all of health care. Clinical studies have shown the most common side-effect of joint mobilization and joint manipulation/adjustment is mild, temporary local muscle soreness. The temporary soreness may be similar to what is experienced when beginning a new exercise or physical activity. Other side-effects, including numbness, headache, dizziness, or an increase in pain or symptoms are rare occurrences and should be reported to your chiropractor immediately.

#### **Consent to Begin Care**

I, \_\_\_\_\_\_, do hereby give consent to be treated by the practitioners of Scarton Chiropractic and Rehabilitation as they deem necessary. I understand that the treatments may consist of joint mobilizations, joint manipulations/adjustments, manual muscle therapies, therapeutic exercises and activities, various forms of traction, physiological modalities, ergonomic instruction, lifestyle modifications, and/or nutritional recommendations.

I am aware of the possible risks and complications as described previously in this summary. I have read, or have had read to me, the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction pror to my signature. I have made my decision voluntarily and freely.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and give consent for treatment.

Print Patient Name	Date:///
Patient Signature:	Date://
Guardian Signature:	Date:///

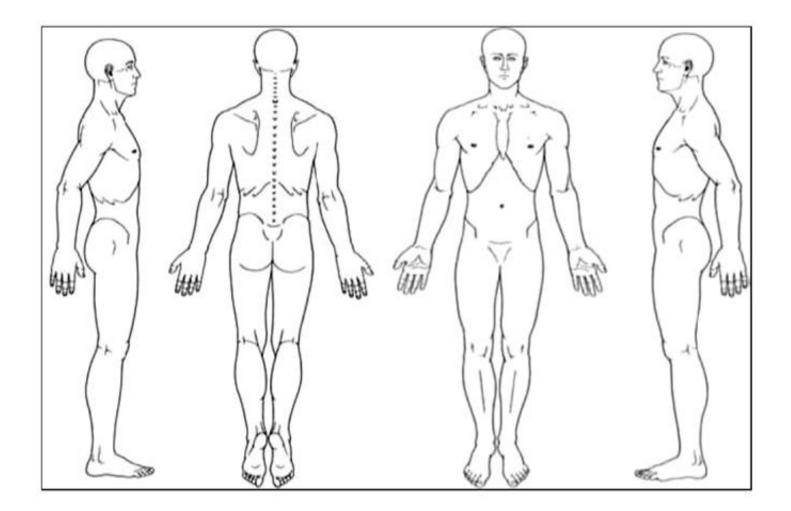
If you have pain, please complete the following. Otherwise skip this page.

#### SYMPTOM DIAGRAM

Name: \_\_\_\_\_

Please be sure to fill this form out extremely accurate. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain and include all affected areas.

### A = Ache B = Burning N – Numbness P = Pins and Needles S = Stabbing O = Other



Date: \_\_\_\_/\_\_\_/