Welcome to Nelson Chiropractic

First Name________________MI____Last______________________Birth Date___/___/___Age____Today's date___/___/___

Address____City________________________State________Zip______________

Home#(   )_____________________Work#(   )______________________ Mobile#(   )___________________________

Email: ____

_____Male ______Female   # of children______   ☐Single   ☐ Married   ☐ Widowed   ☐Separated   ☐ Divorced

Social Security #: ________-________-________   Women: Are you pregnant? ☐ Y ☐ N

Name of Spouse (Parent if under 18): _________________________ Birth date of spouse (Parent if patient under 18): ___/___/___

Place of Employment: ____ Occupation: ___________________________

Primary Care Physician Name/Address/Phone: ____

____

THE FOLLOWING INFORMATION IS BEING UTILIZED TO FORM THE GOVERNMENT DATABASE FOR ELECTRONIC HEALTH RECORDS. PLEASE ANSWER ALL QUESTIONS.

Race (Circle only 1):

American Indian	Native Hawaiian	Other Pacific Islander
Asian	Alaska Native	Decline to State
Black or African American	White	

Ethnicity (Circle only 1):   Hispanic or Latino   Not Hispanic or Latino   Decline to State

Preferred Language: ____

Smoking Status (Circle only 1):

- Current Every Day Smoker   Smoking Start Date: _____________________
- Current Some Day Smoker   Smoking End Date: ______________________
- Former Smoker
- Never Smoker

In an effort to quit smoking, I am currently taking: ____

Do you have any allergies to medication?   Yes   No

If yes, please indicate the following:

Allergy: ________________________________	Allergy: ______________________________________
Reaction: _______________________________	Reaction: _____________________________________
Start Date: ______________________________	Start Date: ____________________________________
End Date: _______________________________	End Date: _____________________________________

Are you currently taking any prescription medication? Yes No

Are you currently taking any over the counter medication? Yes No

If you answered yes to taking either prescription or over the counter medication, please list:

PRESCRIPTION MEDICATIONS:

Medication: ______________________

Route: Oral

Intravenous

Other: ______________________

Frequency: ______________________

Began Use: ______________________

Discontinued Use: ______________________

Medication: ______________________

Route: Oral

Intravenous

Other: ______________________

Frequency: ______________________

Began Use: ______________________

Discontinued Use: ______________________

Medication: ______________________

Route: Oral

Intravenous

Other: ______________________

Frequency: ______________________

Began Use: ______________________

Discontinued Use: ______________________

OVER THE COUNTER MEDICATIONS:

Medication: ______________________

Route: Oral

Intravenous

Other: ______________________

Frequency: ______________________

Began Use: ______________________

Discontinued Use: ______________________

Medication: ______________________

Route: Oral

Intravenous

Other: ______________________

Frequency: ______________________

Began Use: ______________________

Discontinued Use: ______________________

Medication: ______________________

Route: Oral

Intravenous

Other: ______________________

Frequency: ______________________

Began Use: ______________________

Discontinued Use: ______________________

Your Health Profile

***FOR CURRENT CONDITIONS, MARK "C" AND FOR PAST CONDITIONS (3 MONTHS OR LONGER), MARK "P"**

____Numbness/Tingling/Pain in Arms/Hands/Fingers
Right Left Both

____Numbness/Tingling/Pain in Buttocks/Leg/Feet/Toes
Right Left Both

____Headaches/Migranes
____Hip Pain R/L
____Neck Stiffness/Pain
____Back Stiffness/Pain
____Fractured Bones
____Arthritis
____Frequent Colds/Flu
____Diabetes
____Swollen/Painful Joints
____Convulsions/Epilepsy
____Skin Problems
____Cancer
____Anemia
____Tremors
____Blurred Vision (R/L)
____Double Vision (R/L)
____Pain with cough/sneeze
____Chest Pain
____Lung Problems
____Loss of Taste
____Heart Problems
____Stroke
____Gall Bladder Problems
____Digestive Problems
____Prostate Problems
____Kidney Problems
____Loss of Smell
____Loss of Balance
____Dizziness/Vertigo
____Buzzing/Ringing in ears
____Sinus Problems/Allergies
____Nervousness/Anxiety
____Fatigue
____Depression
____Irritability/Mood Swings
____Tension/Stress
____Sleeping Problems
____Cold Hands
____Upset Stomach
____Cold Feet
____Bed Wetting
____Recurring Infections
____Diarrhea/Constipation
____Foot Problems
____Shortness of Breath
____Hot Flashes
____Jaw/TMJ Problems
____Cold Sweats
____Light bothers eyes
____Problems Urinating
____Heartburn/Reflux
____High Blood Pressure
____PMS
____Menopause
____Ulcers
____Other:____

Current Health Condition:

Chief Complaint (why are you here today): ________________________________
____

When did this condition begin? ____________________ Has it ever occurred before? Y/N

Was this due to a trauma or accident? Y / N

If yes, explain (fall, auto accident, sports…):______________________________

When this problem is at its worst, can you explain exactly how it feels?

____

Severity: Mild / Moderate / Severe

Does this pain travel or radiate? Y / N If so, where? ____________________________

Quality (mark all that apply):

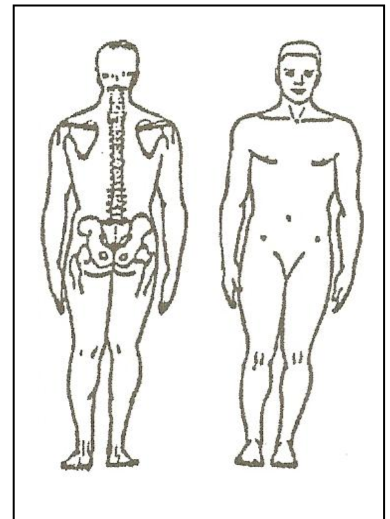
☐ Burning ☐ Diffuse ☐ Dull/ Aching ☐ Localized
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling
☐ Radiating ☐ Other: ____________________________

Is there anything that makes it worse? ________________________________

How often and how long do your symptoms/ pain occur? ______________________

☐ Occasional (0-25%) ☐Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)

***PLEASE MARK THE AREAS OF DISCOMFORT ON THE DIAGRAM BEL**



Daily Activities: Effects of Current Condition on Performance

Activity				
Carrying Grocer ies	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Changing Positions	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Sit to Stand	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Climbing Stairs	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Pet Care	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Driving	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Extended Computer Use	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Household Chores	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Lifting Children	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Reading/ Concentration	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Self Care-Bathing	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Self Care-Dressing	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Self Care-Shaving	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Sexual Activities	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Sleep	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Sitting Still	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Standing Still	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Yard Work	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Walking	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform

Please list any other effects this may have on any recreational activities:
____

Other related information:

What other solutions/ alternatives have you attempted to resolve this condition?
____

Have you ever seen a chiropractor before? Y / N If so, when was your last adjustment?______________________

Are there any other conditions or complaints that the doctor should address? If so, please list and describe.
____
____

On a scale from 1-10 with 10 being the highest, what is your level of commitment to correcting the problem? __________

The health of your family is important for a complete evaluation of your health. Please list any health conditions or concerns you may have about your:

Spouse: ____
Children/ Grandchildren:______________________________________
Parents: ____
Siblings: ____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation. I understand that I am responsible for payment of all services rendered.

______________________________ ______________________
Signature **Date**

Lifestyle Questionnaire

Name: ____ Date: ____

SLEEPING HABITS

1. What position do you sleep? BACK SIDE STOMACH
2. How many hours per night do you sleep? ______________________________________
3. How many pillows do you use? ____

EATING HABITS

4. How many meals do you eat per day? ____
5. How many servings of fruits and vegetables do you eat daily?
   ____
6. Do you drink water on a daily basis? YES NO If yes, how many 8-ounce glasses? ______________________
7. What other beverages do you drink?
   ____
8. Do you take nutritional supplements or vitamins? YES NO
   If yes, please list: ____
9. Do you use artificial sweeteners? YES NO

EXERCISE HABITS

10. How many hours per day do you spend sitting? __________________________standing? _______________________
11. Do you do any structured exercise? YES NO
    If yes, how many hours/days per week?
    ____

LIFESTYLE HABITS

12. Do you smoke? YES NO
    If yes, how often do you smoke: ____
13. Please rate your overall level of stress (0=low, 10=high):
    ____
14. Do you regularly practice meditation, yoga or deep breathing exercises?
    ____
15. What would you like to be able to do that you are currently unable to do because of your pain or symptoms?
    ____
    ____

Informed Consent for Chiropractic Care

Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain this goal. This will prevent confusion or disappointment. Please review the following terms:

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

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

VETEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spine column which causes alteration of nerve function and interferes with the transmission of nerve impulses, resulting in the body's inability to optimally express it's innate given 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 a chiropractic spinal evaluation, we encounter unusual findings outside of the realm of subluxation, we will refer you to the appropriate professional or specialist for specific diagnosis or treatment of those findings. Regardless of the disease, we do not offer to treat you or offer advice for that condition. Our only objective is to eliminate interference to the nerves of the spine and to allow your body to function as optimally as your given potential allows. Our method is specific adjustments to the spine to correct vertebral subluxation.

Additional treatment modalities may be utilized in conjunction with adjustments in our office for the use of pain management, postural and spinal strengthening or conditioning and increasing range of motion in order to improve function during daily activities of living. These modalities may include ice, electrical muscle stimulation, therapeutic activities and exercises, traction and recommendation for use of nutritional supplementation.

I understand the nature and purpose of chiropractic adjustments and other mentioned treatment modalities. I request and consent to these chiropractic adjustments, therapeutic modalities and other chiropractic related procedures by Dr. Rodney L. Nelson or other licensed doctors of chiropractic who may be employed or engaged in practice at Nelson Chiropractic. I have been advised that although the incidence of complications associated with chiropractic care is very low, the rare possible complications that may occur include, but are not limited to, fractures, disc injuries, dislocations, sprains, irritation of a disk condition or other musculoskeletal or neurological injury. One of the rarest complications associated with chiropractic care, occurring at a rate of one instance in one million to one instance per two million cervical spine or neck adjustments may be a vertebral artery injury that could lead to stroke.

I, ____ have read and fully understand the above statements.
(Print Patient Name)

I understand and accept the risks associated with chiropractic care and give my consent to the evaluations and chiropractic care, including spinal adjustments , that I may receive in this office. I therefore give informed consent to begin my chiropractic evaluation and any further care on this basis.

____ ______________________________

Signature of Patient or Legal Guardian Date

I authorize Dr. Rodney Nelson or any other licensed Doctor of Chiropractic to take x-rays. I do not suspect nor know positively that I am or may be pregnant at this time. I release Dr. Rodney Nelson and other doctors in this office from any and all liability from complications from the diagnostic or treatment procedures utilized in the office.

____ ______________________________

Signature of Patient or Legal Guardian Date

____ ______________________________

Witness Signature (Office Staff) Date