

Welcome to Quartell Chiropractic



Patient Information contained within this form is considered strictly confidential.

Your responses are important to help us better understand you and any health issues you may be facing. To ensure the delivery of the best possible treatment and service to

Please print clearly.

you please fill this form out to the best of your ability. Thank you.

Name _____ Birth Date ____ / ____ / ____ Age _____ Sex M F
 Address _____ City _____ State _____ Zip _____
 Phone _____ Alt. Phone _____ Employer _____
 Marital Status Single Married Divorced Significant Other Spouse's Name _____
 Emergency Contact _____ Phone _____ Referred By _____
 Email _____ Would you like to receive specials via text or email? _____

Do you have health insurance? Yes No If yes, who is your insurance company? _____

Have you ever received chiropractic care? Yes No Was it a favorable experience? Yes No

Have you ever received a massage? Yes No What type of massage do you prefer? Swedish Deep Tissue

Please circle any areas of complaint on the diagram below

Height _____ ft _____ in Weight _____ lbs Are you happy with your weight? Yes No

Smoking Status Never Smoker Current Smoker Former Smoker

Describe your current unwanted health conditions

On a scale from 1-10, with 10 as the worst, please rate your condition:

Condition began on ____ / ____ / ____ Worsening / Improving / Not Changing

Is your condition related to any of the following?

Work Injury Auto Accident Home Injury Slip & Fall Overuse Posture
 Other _____

Has this occurred before? Yes No

Are you taking any of the following medications?

Nerve Pills Pain killers Muscle Relaxers Blood Pressure Insulin Who is your medical physician? _____

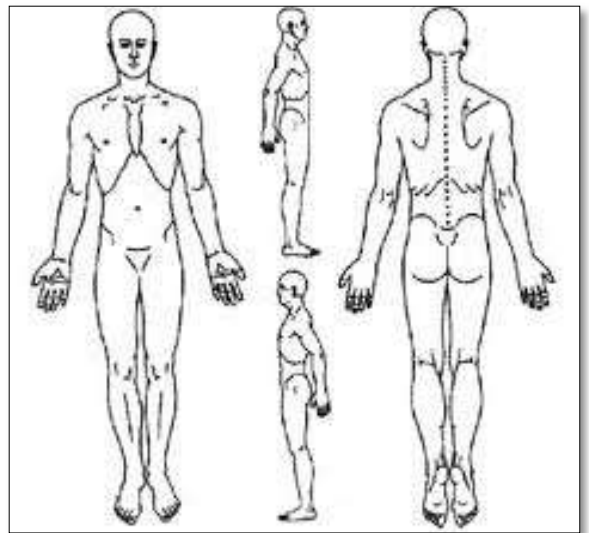
List any other medications you are currently taking. _____

List any allergies you may have. _____

Have you experienced any of the following in the last 6 months?

Headaches Neck Pain Back Pain Joint Pain Fatigue Numbness Sinus/Allergies Sciatica Blood Pressure Poor Digestion

On a scale of 1-10, where do you see your overall health? Poor 1 2 3 4 5 6 7 8 9 10 Excellent



This box is reserved for the Doctor's use. Please use the back of the form if additional space is needed to record any information.

Patient accepted for care? Yes No Services: Exam Cerv X-Ray Lumb X-Ray Chiropractic Adjustment Neuromuscular Massage Referral: _____

Please mark each of the following diseases you have had, and give age and brief description if possible.

- | | | |
|-----------------------------------------|----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

Have you been tested HIV positive? Yes No Confidential health record

Please mark each item below for each sign or symptom you presently have or previously had in the last 6 months. Also, please **circle** any condition that is in your family history.

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

What outcome do you hope to have with your examination and treatment in our office? _____

Please **CIRCLE** the type of Care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as continually drying a wet floor that got wet from a leak, but not fixing the hole in the roof.

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while *correcting the cause of the problem*. Corrective care varies in the length of time, but is more long lasting.

Or

Let the doctor select the type of care necessary for your condition.

- 1) I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Quartell Chiropractic will assist me in making collection from the insurance and that any amount authorized to be paid directly to Quartell Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment and any necessary fees associated with collection.
- 2) In line with new treatment methods, Quartell Chiropractic has adopted an open care format. Although we use an open format, if at any time you would like an increase in privacy when meeting with the doctor, please inform the doctor and we will gladly accommodate you.
- 3) I hereby authorize the doctor to treat my condition, as he/she deems appropriate.

Patient Privacy Rights & Regulations

It is our office policy that all of your private and health related information will be held in our strictest confidence and only released to another party at your written request. You, the patient, will be able to access your file at any time. Also, there is always a packet of your privacy rights and regulations available for your review in our office, as well as one to take home.

Patient's Signature X _____ Date _____

Guardian or Spouse's
Signature Authorizing Care X _____ Date _____