Health First Chiropractic & Wellness Center

PATIENT INFORMATION (Adult – 18+)

Please print clearly:

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

CELL #: (_____) _____- _____

HOME #: (_____) _____- _____

E-MAIL: _____

DATE OF BIRTH: _____/_____/_____ M / F

OCCUPATION: _____

STATUS: Single / Married / Divorced / Widow

Spouse's Name _____

EMERGENCY CONTACT:

Name_____

Phone#: (_____) _____- _____

CHILDREN: YES / NO

Name: _____ Age: _____

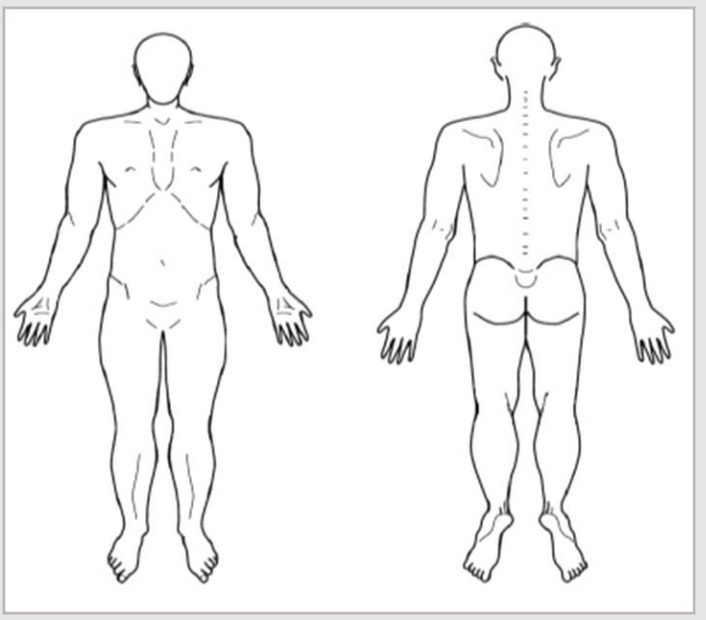
Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Whom may we thank for referring you?

_____



Primary reason you are seeking our help:

_____

_____

If you have any specific areas you would like us to address, please mark the area of concern on the above diagram.

Does the reason for your visit today involve:

Auto Accident claim? YES / NO

Workman's Compensation claim? YES / NO

Disability / Medicare claim? YES / NO

How long have you had this problem?

_____

Have you been seen by a chiropractor before?

YES / NO

If yes, Who? _____

Reason for care? _____

_____

Approximate dates of care: _____

Health First Chiropractic & Wellness Center
530 Madison Street - St. Charles, MO 63301
(636) 946-3600 FAX (636) 946-3019

MEDICAL HISTORY:

List all operations and approximate dates: _____

_____

List all medications you are currently taking and why:

1. _____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

FEMALES ONLY:

Are you or could you be pregnant? YES / NO When was your last period? _____

Please list any concerns you feel we need to know about: _____

What are you seeking to accomplish from our office? Check all that apply:

- ☐ Chiropractic Corrective Care: Specific plan of chiropractic care and exercises to remove nerve interference and restore function to your spine and nervous system.
- ☐ Nutrition: Are you interested in learning about what God designed you to eat?
  Area of Greatest Concern: _____
- ☐ Movement: Are you interested in learning about how God designed you to move?
  Area of Concern: _____
- ☐ Fitness Coach: Are you interested in being recommended to a Fitness / Rehab Trainer? Are you interested in rehabilitation of a particular joint or injury recovery?
  Area of Concern: _____
- ☐ Massage Therapy: Are you interested in releasing muscle tension, creating mental relaxation as well as many other benefits of massage therapy?
- ☐ Think Well: Are you interested in learning about how God designed you to think so that you can alleviate "Thought Stressors" that negatively affect your well-being?
- ☐ Hair Tissue Mineral Analysis test: Are you interested in finding out if you have toxicities or deficiencies that could also be affecting your sleep, hormones and your energy levels?
- ☐ Ideal Body Weight: Are you interested in learning how to reach and maintain your optimal body weight?

I understand this office DOES NOT participate in, not a provider for, or accept ANY Insurance/Medicare/Medicaid. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I understand this office is not offering to treat symptoms and disease. I understand the purpose of my examination is to determine how to improve the overall health of my spine and nervous system. I hereby authorize the doctors at Health First Wellness Center and/or their assistants to perform my initial health examination. I certify that the information in this entire intake form is true and correct.

_____ _____

Patient Signature Date

Review of Systems

Name: _____ Date: _____

1. General
   - ☐ No Problems
   - ☐ Fever or Chills
   - ☐ Unexplained hair loss

2. Eyes
   - ☐ No Problems
   - ☐ Eye pain
   - ☐ Blurred vision
   - ☐ Loss of vision

3. Ears/Nose/Mouth/Throat
   - ☐ No Problems
   - ☐ Dizziness
   - ☐ Dental Problems
   - ☐ Swollen glands in neck
   - ☐ Sore throat/pain with swallowing
   - ☐ Mouth sores

4. Cardiovascular
   - ☐ No Problems
   - ☐ Chest Pain (sharp/crushing/heaviness)
   - ☐ Heart racing (palpitations)
   - ☐ Sudden shortness of breath at night or when lying down
   - ☐ Leg pain in calf or thigh
   - ☐ Aching/burning in legs
   - ☐ Fainting spells
   - ☐ Swelling of legs (edema)

5. Respiratory
   - ☐ No Problems
   - ☐ Shortness of breath
   - ☐ Night sweats
   - ☐ Cough/coughing up blood

6. Genitourinary
   - ☐ No Problems
   - ☐ Pain when urinating
   - ☐ Urinating more frequent than usual
   - ☐ Pain during sex
   - ☐ Blood in urine
   - ☐ Bladder infection/other infections
   - ☐ Change in sex drive (libido)

7. Women
   - ☐ No Problems
   - ☐ Irregular periods
   - ☐ 3 or more yeast infections in a year

8. Gastrointestinal
   - ☐ No Problems
   - ☐ Decreased appetite
   - ☐ Nausea/vomiting
   - ☐ Constipation
   - ☐ Heartburn
   - ☐ Stomach pain
   - ☐ Diarrhea

9. Musculoskeletal
   - ☐ No Problems
   - ☐ Joint pain
   - ☐ Numbness, tingling in arms, legs, face
   - ☐ Limited motion of arms, legs, back or neck
   - ☐ Swelling/redness, if so where: _____

10. Neurological
   - ☐ No Problems
   - ☐ New headaches
   - ☐ Headaches with vision changes
   - ☐ Arm/leg weakness
   - ☐ Repeated bad headaches
   - ☐ Problems with memory or speech

11. Endocrine
   - ☐ No Problems
   - ☐ Thirsty all day
   - ☐ Increased facial hair (females only)
   - ☐ Weight gain/loss
   - ☐ Intolerant to temperature changes

12. Lymph
   - ☐ No Problems
   - ☐ Swollen glands (armpit, groin, neck)

13. Skin
   - ☐ No Problems
   - ☐ Changes in skin
   - ☐ Rash (palm of hands, sole of feet)
   - ☐ Sores or rash on skin

14. Allergies
   - ☐ No Problems
   - ☐ Hives/skin rashes
   - ☐ Allergic reaction to drugs
   - ☐ Allergic reaction to foods

15. Other: _____

_____

Health First Wellness Chiropractic Clinic

Palmer Specific Chiropractic

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND
(Patient's Name)
AGREE AS FOLLOWS:

1. The Practice's Privacy notice will be offered to me (upon request) prior to my signing this Consent. The Privacy notice includes a complete description of the uses and /or disclosures of my *protected health information* ("PHI") necessary for the Practice to provide treatment of me, and also necessary for the Practice to obtain payment of that treatment and to carry out its' health care operations. The practice explained to me that the Privacy notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its' privacy practices that are described in its' Privacy notice, in accordance with applicable law.
3. The Practice may use and /or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific health care operations.
4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the practice.
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice had already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship

Date Signed _____/_____ /_____ Witness: _____

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530 Madison Street - St. Charles, MO 63301
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Health First Chiropractic Clinic
Palmer Specific Chiropractic

This Document Constitutes Informed Consent for Chiropractic Examination and Care

When a patient seeks straight chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Straight chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

The Vertebral subluxation is the misalignment of spinal bones causing interference to the mental impulses traveling over the nerve pathways. The objective of straight chiropractic is to analyze the spine and locate and correct these vertebral subluxations. The straight chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

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 examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I hereby authorize the doctor to perform a chiropractic examination to determine the presence of vertebral subluxation.

I hereby authorize the taking of x-ray films if necessary. I further agree that the above-mentioned doctor shall be the custodian of these x-rays.

All questions regarding the doctor's objective pertaining to detection of vertebral subluxation have been answered to my complete satisfaction.

I, _____ have read and fully understand the above statement.
PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I_____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic examination and adjustment if necessary.

_____ _____
(SIGNATURE) (DATE)

Health First Chiropractic & Wellness Center
530 Madison Street - St. Charles, MO 63301
(636) 946-3600 FAX (636) 946-3019

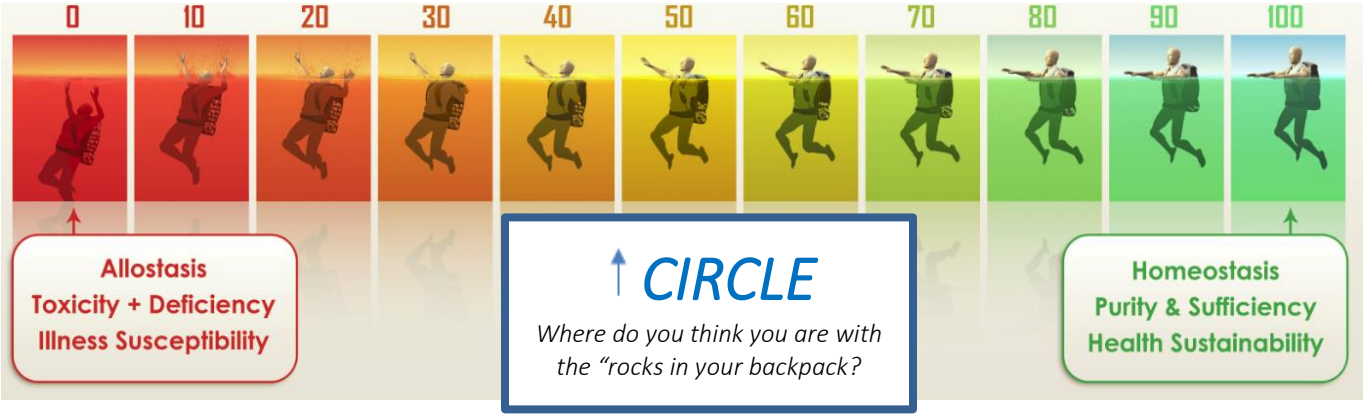
Name: _____ Date: _____

Current Health Profile

Everyone has "rocks" in our health backpack that can "sink" our future health.
Every area we are deficient in how we eat, move, and think - we add a rock.
Every area we are toxic in our lifestyle, i.e., lack of exercise,
poor eating habits, mental/emotional stress – we add a rock.

Our office is committed to identifying and helping you remove your rocks.

Where do you think you are?



Take the following health profile to help identify your health "rocks".
Your honest answers will give us the ability to better address how to improve your future health.

Pain and Mobility

Please circle your answers

Am I currently using medication to treat pain, inflammation, or headache?	NO (0)		YES (5)			
On average, over the past 30 days, has pain limited your ability to attend work/school?	Never/Very Rarely (0)		1-2 times per week (3)	3 times per week (5)		3+ times per week (10)
I would rate my typical level of pain in the past week as: *(0= no pain at all; 5= worst pain possible)*	No Pain 0 (0)	1 (2)	2 (5)	3 (7)	4 (10)	High Pain 5 (15)
I would rate my ability to move (mobility/balance/strength) in the past week as: *(0= low/average movement ability; 5= high overall movement ability)*	Low Ability 0 (15)	1 (10)	2 (7)	3 (5)	4 (2)	High Ability 5 (0)

Pain and Mobility - Total Score	

You Are What You Eat

Please circle your answers

How many meals per week do you include vegetables?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (3)	3+ times per week (0)
Do you buy more non-organic vegetables than organic?	NO (0)	YES (10)		
How often do you consume cereal, whole grain products, pasta, rice, or bread?	Never/Very Rarely (0)	1-2 times per week (5)	3-4 times per week (15)	4+ times per week (20)
Do you have any trouble with wheat or gluten?	NO (0)	YES (10)		
How often do you consume milk or cheese?	Never/Very Rarely (0)	1-2 times per week (5)	3 times per week (10)	3+ times per week (15)
Do you have any trouble with cow milk or cow milk products?	NO (0)	YES (10)		
How often do you use products containing hydrogenated/partially hydrogenated oils (Vegetable/Canola/Shortening, etc.)?	Never/Very Rarely (0)	Once per week (3)	Twice per week (5)	3+ times per week (10)
Do you regularly consume “low-fat” or “fat-free” products?	Never/Very Rarely (0)	Once per week (1)	Twice per week (3)	3+ times per week (5)
Do you eat nuts /seeds that are roasted and /or salted?	NO (0)	YES (3)		
Do you regularly eat/drink artificial sweeteners such as Sweet-n-Low, Equal, Splenda, or NutraSweet?	Never/Very Rarely (0)	Once per week (5)	Twice per week (10)	3+ times per week (20)
Do you use standard white table salt?	NO (0)	YES (5)		
Do you eat boxed or processed foods more than three times a week?	NO (0)	YES (10)		
How often do you eat from fast food restaurants like McDonald’s, Wendy’s, etc.?	Never/Very Rarely (0)	1-2 times per week (5)	3 times per week (10)	3+ times per week (20)
Do you drink city tap water?	NO (0)	YES (10)		
How often do you consume drinks containing caffeine and/or sugar (i.e., coffee, tea, sodas, fruit juices, corn syrup or added sugar)?	Never/Very Rarely (0)	1 cup per day (10)	2 cups per day (15)	More than 2 cups per day (20)
How often do you eat some form of store-bought dessert such as ice cream, cookies, donuts, cakes, or pies?	Never/Very Rarely (0)	Once per week (5)	Twice per week (10)	3+ times per week (15)
How much alcohol do you consume?	None (0)	Once per week (10)	Several per week (15)	Daily (20)
Do you take an Omega 3 supplement?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (1)	4+ times per week (0)
Do you take a Vitamin D supplement?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (1)	4+ times per week (0)
Do you take a Probiotic supplement?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (1)	4+ times per week (0)

You are What you Eat - Total Score	

You are When You Eat

Please circle your answers

Do you frequently skip meals?	NO (0)	YES (5)		
How many times is your breakfast primarily carbohydrates (toasted breads/cereal/oatmeal/pancakes, etc.)?	Never/Very Rarely (0)	1-2 times per week (1)	3 times per week (5)	3+ times per week (10)
Do you often get hungry or crave sweets within two hours after eating meals?	NO (0)	YES (5)		
Do you have difficulty burning fat around your belly, hips, or thighs even with regular exercise?	NO (0)	YES (5)		
Do you eat your largest meal in the evening?	NO (0)	YES (5)		
Do you often eat or snack after 7PM?	NO (0)	YES (10)		
You are When You Eat -Total Score				

Please list all the OTC (over the counter) health supplements/dosages you are taking:

Digestion

Please circle your answers

How often do you experience lower abdominal bloating?	Never/Very Rarely (0)	1-2 times per week (1)	3 times per week (5)	3+ times per week (10)
Do you frequently have loose stools or diarrhea?	No (0)	Once per week (5)	More than 3x per week (10)	
How often do you experience constipation or stools that are compact/hard to pass?	Never/Very Rarely (0)	1-2 times per week (1)	3 times per week (5)	3+ times per week (10)
Do you crave certain foods such as bread, chocolate, certain fruit, and dairy products if you have not eaten them in a day or two?	NO (0)	YES (10)		
Have you had your gallbladder removed?	NO (0)	YES (5)		
How often do you have indigestion or heartburn?	Never/Very Rarely (0)	1-2 times per week (3)	3 times per week (5)	More than 3x per week (10)
Do you have a history of using anti-acids, proton pump inhibitors, or anything that blocks acid?	NO (0)	YES (10)		
Do you get a headache after eating?	Never/Very Rarely (0)	1-2 times per week (5)	3+ times per week (10)	
How frequently do you have bowel movements?	Same as meal frequency (0)	1-2 times daily (1)	Every few days (5)	Only when taking something to help regularity (10)
Digestion -Total Score				

Possible Toxicity Indicators

Please circle your answers

Do you take daily prescription medication?	Very Rarely (0)	1 to 3 different medications (50)	4 or more different medications (100)	
Would you consider your life to be:	Stress Free (0)	Mildly Stressfu1 (10)	Very Stressful (40)	
Do you have or have you had dandruff in the past year?	NO (0)	YES (10)		
Do you suffer from any kind of skin condition (rash, eczema, psoriasis, etc.)?	NO (0)	YES (20)	If yes, what?	
Do you frequently experience itching in your ears or rectal region?	No (0)	1-2 days per week (10)	3+ days per week (20)	
Possible Toxicity Indicators - Total Score				

Sleep Wake Cycles

Please circle your answers

How often do you wake up feeling un-rested and in need of more sleep?	Never/Very Rarely (0)	Once per week (1)	3 times per week (5)	More than 3x per week (10)
Do you commonly go to bed after 10:00PM?	NO (0)	YES (10)		
Do you sleep on your stomach or in the fetal position?	NO (0)	YES (20)		
How often do you wake up at night between 2AM and 4AM and have a hard time falling back to sleep?	Never/Very Rarely (0)	3 times per week (10)	More than 3x per week (20)	
Sleep Wake Cycles - Total Score				

Exercise – Answer these questions based <u>on average, over the past 30 Days</u>:

Please circle your answers

I perform at least 30 minutes of exercise the following number of DAYS per WEEK:	7 (0)	6 (3)	5 (5)	4 (7)	3 (10)	2 (13)	1 (15)	0 (20)
I perform exercise with weights or resistance bands?	YES (0)	NO (10)						
I perform stretches for flexibility and range of motion?	YES (0)	NO (20)						
I typically SIT at work/school, commuting, and during my leisure time for the following number of combined HOURS per DAY?	Never/Very Rarely (0)	1-2 hours (5)	2-4 hours (10)	More than 6 hours (15)				
I would rate my current overall FUNCTIONAL ABILITY (mobility, balance, strength) to perform physical activities of daily life as:	Excellent (0)	Good (5)	Fair (10)	Very Low (20)				
Exercise - Total Score								

Lifestyle

Please circle your answers

I understand my current health issues are affected by or a result of my lifestyle choices.	YES (0)	NO (20)		
Is there anything that you know you could do to improve your health, but you are not currently doing?	NO (0)	YES (10)		
Do you smoke?	NO (0)	YES (20)		
Do you consider yourself overweight?	NO (0)	YES (20)		
Do you consider yourself underweight?	NO (0)	YES (10)		
Do you have your nervous system evaluated by a chiropractor for subluxation/nerve interference at least every 2-4 weeks?	YES (0)	NO (20)		
During my lifetime, I have suffered the following number of SIGNIFICANT SPINAL TRAUMAS or INJURIES (from falls, accidents, work, or sport activities, etc.) that have resulted in neck or back pain, and/or the need to limit activities:	0 (0)	1 (10)	3 (15)	4+ (20)

Lifestyle - Total Score	

TOTALS:

Pain and Mobility *(page 1)* - Total Score	
You are What you Eat *(page 2)* - Total Score	
You are When You Eat *(page 3)* - Total Score	
Digestion *(page 3)* - Total Score	
Possible Toxicity Indicators *(page 4)* - Total Score	
Sleep Wake Cycles *(page 4)* - Total Score	
Exercise *(page 4)* - Total Score	
Lifestyle *(page 5)* - Total Score	

Current Health Profile Total Score	