

Past Medical History

Surgeries

Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No

Broken Bones

Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No

Serious Illness

Year Diagnosed _____ Type of Illness _____
 Year Diagnosed _____ Type of Illness _____

Work Injuries

Year _____ Body Region _____ Still have pain ___ Yes ___ No
 Year _____ Body Region _____ Still have pain ___ Yes ___ No

Auto Accidents

Year _____ Body Region Injured _____ Still have pain ___ Yes ___ No
 Year _____ Body Region Injured _____ Still have pain ___ Yes ___ No
 Year _____ Body Region Injured _____ Still have pain ___ Yes ___ No

Sports Injuries or any other Trauma to the Head, Neck Back

Year _____ Body Region Injured _____ Still have pain ___ Yes ___ No
 Year _____ Body Region Injured _____ Still have pain ___ Yes ___ No
 Year _____ Body Region Injured _____ Still have pain ___ Yes ___ No

Family Medical History

		Diabetes	Heart	Blood Pressure	Stroke	Circulation	Cancer	Stroke	Other
Mother	d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you smoke? Yes / No # Cigarettes a day? ___ Packs a day? ___ History drug abuse? Yes / No
 Do you drink alcohol? Yes / No # of glasses per day? ___ Alcoholic Recovering Alcoholic
 Medications you are currently taking: _____

Review of Symptoms

Please Circle any complaints that you are experiencing

Head Injury	Yes / No
Headaches	Yes / No
TMJ Pain / Jaw Pain	Yes / No
Neck Pain	Yes / No
Mid Back Pain	Yes / No
Chest Pain	Yes / No
Rib Pain	Yes / No
Low Back Pain	Yes / No
Pelvic Pain	Yes / No
Tailbone Pain	Yes / No
Right/Left Shoulder Pain	Yes / No
Right/Left Arm Pain / Tingling / Numb	Yes / No
Right/Left Hand Pain / Tingling / Numb	Yes / No
Right/Left Leg Pain / Tingling / Numb	Yes / No
Right/Left Foot Pain / Tingling / Numb	Yes / No
Finger / Toe Pain / Tingling / Numb	Yes / No
Right/Left Elbow Pain	Yes / No
Right/Left Wrist Pain	Yes / No
Right/Left Hip Pain	Yes / No
Right/Left Knee Pain	Yes / No
Right/Left Ankle Pain	Yes / No
Trouble Breathing	Yes / No
Swelling	Yes / No
Muscle Spasms	Yes / No
Muscle Weakness	Yes / No
Numbness / Tingling	Yes / No
Coordination Difficulties	Yes / No
Dizziness / Vertigo	Yes / No
Vision Disturbance	Yes / No
Motion Restricted	Yes / No
Radiating Symptoms	Yes / No
Sleep Disruption	Yes / No
Anxiety	Yes / No
Night Sweats	Yes / No
Depression	Yes / No
Mood Swings	Yes / No
Memory Loss	Yes / No
Ringing in Ears	Yes / No
Fatigue tired a lot	Yes / No
Bruises	Yes / No
Scars	Yes / No
Nausea	Yes / No
Vomiting	Yes / No
Change in Taste / Smell	Yes / No
Abdominal Pain	Yes / No

Authorization For Care

The Nature of Chiropractic: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Other procedures such as hot/cold packs, ultrasound, massage chairs/machines, wobble chairs, and cervical traction units may also be used.

Possible Risks: As with all health care procedures, complications are possible. The most common complications are stiffness or soreness after the first few days of treatment. Rare complications could include fractures, muscular strain, ligament sprain, dislocation of joints, or injury to intervertebral discs, nerves or the spinal cord. Even less likely complications would be cerebrovascular injury or stroke which could occur upon severe injury to arteries of the neck.

Probability of Risks: The risks of complications due to chiropractic treatment are rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke is estimated at one million to one in twenty million, and can be even further reduced by screening procedures.

Other Treatment Options and Their Risks:

- *Over-the-counter analgesics:* the risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical Care:* Typically involves the use of anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable effects and patient dependence in a significant number of cases. (100,000 deaths/year from properly prescribed medication – JAMA 04/15/98)
- *Hospitalization:* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. (2.2 million hospitalizations/year from properly prescribed medications – JAMA 04/15/98)
- *Surgery:* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment can damage the spinal cord and nerves significantly because the **subluxations** causing stress to your body will not be corrected. In addition, other degenerative changes can take place, including formation of adhesions and scar tissue. These changes further reduce skeletal mobility, induce chronic pain cycles, and make future rehabilitation more intensive.

I authorize and agree to allow First Choice Chiropractic to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration. First Choice Chiropractic will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

_____	_____	_____
Patient Printed Name	Patient's Signature	Date
_____	_____	_____
Witness Printed Name	Witness's Signature	Date