Personal Health History Form

Welcome to Drs. Bamberger Chiropractic, Fitness & Nutrition!

The following is an outline of procedures of care:

Step One:
All new patients are requested to fill out this personal health history questionnaire completely as possible.

Step Two:
Please read and sign all other forms.

Step Three:
A one-on-one consultation with the doctor will be done to discuss your health issues and goals, uncover the layers of past damage done and to help determine what may be the cause.

Step Four:
A comprehensive chiropractic examination and evaluation including those tests necessary will be performed to further help determine the precise cause of your problem.

Step Five:
The doctor will advise you if additional laboratory tests or x-rays are needed.

Step Six:
You will be asked to schedule a follow-up appointment called the "Report of Findings / Patient's Action Steps" at which time the cause of your current condition will be discussed. After reviewing your case, the doctor will decide if you will be accepted as a patient and a thorough explanation of care recommendations and *the action steps you need to take* to obtain the results you desire.

Step Seven:
We will initiate care together and start you on your path to creating your optimum inner health and wellness.

- Congratulations on taking the first steps to creating true wellness from within.

Remember your health outcomes… are based on your health choices!

PERSONAL HISTORY

Confidential Patient Health Record

Referred by:___________________________________ Today's Date: _____________-_____________-_____________

Name:____
First Middle Initial Last

Address: ____

City:____ State:________________ Zip code:_______________________

Home phone: [ ] ____________________________ Cell phone: [ ] _____________________________________

E-mail:____

Birth date: __________-__________-_____________ Age:__________ Height:____________Weight:_____________

Sex: [ ] M [ ] F Circle one: Married Single Widowed Divorced Separated

Social security # _________-_________-___________ Driver's license #:______________________________________

Business employer:______________________________ Type of work:____

Business phone: [ ] ________________________ Business e-mail:______________________________________

Name of spouse:________________________________ Spouse's social security #:__________-________-___________

Spouse's employer:______________________________ Business phone: [ ] ________________________________

Child:______________________ Age:_____ Have they ever been checked by a Chiropractor? [ ] Yes [ ] No

Child:______________________ Age:_____ Have they ever been checked by a Chiropractor? [ ] Yes [ ] No

Child:______________________ Age:_____ Have they ever been checked by a Chiropractor? [ ] Yes [ ] No

Name of emergency contact:____

Relationship:___________________________________ Phone number : [ ] ________________________________

Who is responsible for your bill? You and [ ] Spouse [ ] Workers' compensation [ ] Auto insurance [ ] Medicare

[ ] Personal health insurance (Name):____

I.D. # / Group #:____

CHIROPRACTIC AWARENESS

- Did you know that chiropractors are actually nervous system doctors? [ ] Yes [ ] No
- Did you know that the nervous system controls all bodily functions and systems? [ ] Yes [ ] No
- Did you know that chiropractic is the largest natural healing profession in the world? [ ] Yes [ ] No
- Did you know that most spinal misalignments [subluxations] and the associated degeneration / ill health [nervous system dysfunction] that we see in our patients can begin at birth or early childhood without any associated pain? [ ] Yes [ ] No
- Did you know that regular chiropractic care could assist your body to function at a higher level of health throughout life? [ ] Yes [ ] No

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PAST HISTORY OF SICKNESS / LOSS OF WELLNESS

The human body is designed to be healthy as long as there is no interference in the innate expression of your health. Throughout life, stressful events (physical, emotional and chemical) occur which damage and diminish your health expression. This case history will help uncover the layers of damage (especially to you nerve system) that have resulted in the interruption of your health expression. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Sport injuries, accidents or falls:____

Vehicular accidents:____________________ Work injuries:____________________

Major surgery / operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Tubes in the ears [ ] Spinal surgery

[ ] Broken bones [ ] Other:____

Hospitalizations (other than above):____

Drugs you **currently** take: [ ] Pain killers [ ] Muscle relaxers [ ] Blood pressure [ ]Blood thinner [ ] Insulin [ ]

Birth control [ ] Hormone replacement [ ] Other:________________________________

Over-the-counter drugs you **currently** take: [ ] Aspirin [ ] Tylenol [ ] Advil [ ] Motrin [ ]

Other:____

Do you wear a heal lift / shoe lift / arch support?

____

Below is a list of diseases / conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have or had:

[ ] Arthritis	[ ] Asthma	[ ] Atherosclerososis	[ ] Blood pressure problems
[ ] Cancer	[ ] Diabetes	[ ] Heart disease	[ ] Hemophilic
[ ] Migraines	[ ] Multiple sclerosis	[ ] Osteoporosis	[ ] Stroke / Ministroke / TIA
[ ] Lupus	[ ]		

Other:____

Have you ever been tested HIV positive? [ ] Yes [ ] No

Check any of the following conditions you have had the past 6 months:

Immune System
[ ] Allergies
[ ] Chronic infections
[ ] Chronic earaches
[ ] Chronic cough
[ ] Frequent colds / flu
[ ] Fever / Chills
[ ] Chronic fatigue

Musculo-Skeletal
[ ] Neck pain
[ ] Mid-back pain
[ ] Low back pain
[ ] General stiffness
[ ] Joint pain / Stiffness
[ ] Jaw problems
[ ] Walking problems / Foot drop

Gastro-Intestinal
[ ] Poor / Excessive appetite
[ ] Excessive thirst
[ ] Frequent nausea
[ ] Vomiting
[ ] Constipation
[ ] Diarrhea
[ ] Gas / Bloating after meals
[ ] Abdominal cramps
[ ] Weight loss / gain
[ ] Heartburn
[ ] Hemorrhoids
[ ] Black / Bloody stools
[ ] Colitis
[ ] Liver problems
[ ] Gall bladder problems

Male
[ ] Prostate problems
[ ] Sexual dysfunction

Nervous System
[ ] Headaches
[ ] Numbness / Tingling
[ ] Dizziness / Fainting
[ ] Forgetfulness
[ ] Confusion / Depression
[ ] Convulsions / Seizures
[ ] Stress / Nervous / Loss of sleep

Genito-Urinary
[ ] Discolored urine
[ ] Painful urination
[ ] Excessive urination / ↑Frequency
[ ] Urinary incontinence / Retention
[ ] Bladder / Kidney problems

Cardio-Respiratory
[ ] Chest pain
[ ] Shortness of breath
[ ] Heart problems
[ ] Irregular heartbeat
[ ] Varicose veins
[ ] Ankle swelling
[ ] Lung problems / Chronic cough
[ ] Congestion / Bronchitis

Eyes, Ears, Nose & Throat
[ ] Vision problems
[ ] Earaches
[ ] Hearing difficulty / ringing
[ ] Dizziness
[ ] Sore throat
[ ] Excessive mucus
[ ] Sinus infections
[ ] Stuffed nose

Female
Birth control Yes / No
Birth control pill Yes / No
Pregnant? Yes / No / Not Sure
Last period?____/_____/_____
Patient Initials:_____________

Female (continued)
[ ] Sexual dysfunction
[ ] Menstrual cramps
[ ] Vaginal pain / Infection
[ ] Breast pain / Lumps
[ ] Breast implants

General (please circle and fill in blanks)
Nutrition: sugar / soda / caffeine flour / dairy / wheat / processed / fast foods / fried foods / fluorinated products
Vitamins / Supplements:______________
____
____
Exercise: Yes / No
Aerobic - How often / week:__________
Strength - How often / week:_________
Stretch: - How often / week:__________
Sleep: Hours / night:_______________
on: Mattress & box spring / waterbed futon / Air / other:__________________
Sleep on: back / stomach / side (L or R)
Use a cervical support pillow? Yes / No
Work: Prolonged: sitting / standing bending / lifting
Labor: light / heavy / computer work
Stress: work / family / physical emotional / chemical
Do you smoke? Yes / No
___ packs/day for the past _____ years
Metal implants? Yes / No
Where?____________________________

Family History The following members have same or similar problems as I do:
[ ] Spouse [ ] Child [ ] Brother [ ] Sister [ ] Mother [ ] Father

REASON FOR SEEKING CHIROPRACTIC CARE

Patient Information Regarding Reason For Seeking Care: [ ]

Finally, the years of continued layering of damage manifest as acute or chronic symptoms which brought you to our office.

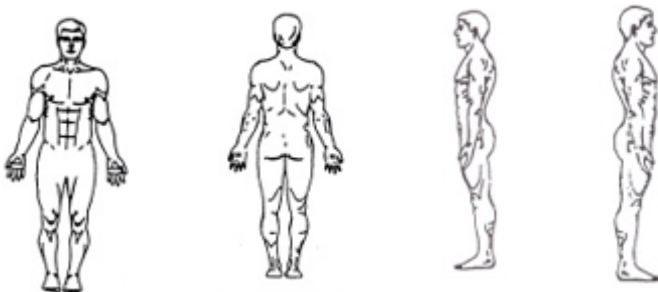
Present unwanted health condition, please describe how injury occurred? Try remembering things you did the week prior to the symptoms? (Yard work, washing car, sport activity, slept on couch,…):________________________________

____

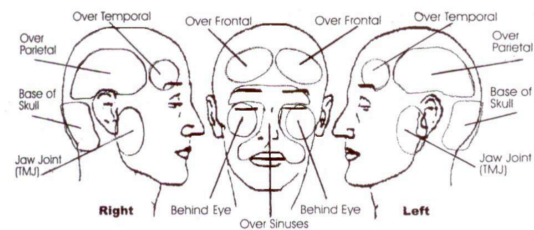
____

____

Please mark location(s) of symptoms on figures below:



Headache Information - Please mark locations below:



Injury related to: automobile accident / work injury - Have you reported your accident to your employer? [ ] Yes [ ] No

Do you ever experience any of these symptoms while working? [ ] No [ ] Yes, if yes please describe what activities at work might be causing you to experience these complaints:____

____

____

CURRENT SYMPTOMS / STATE OF ILL HEALTH / RESTRICTIONS

1. What caused the onset of symptoms? Overexertion / Strenuous position / Fall / Slip / Trip / Other:________________
2. When did first symptom appear?______________ Occurred before? [ ] Yes [ ] No How long ago?_____________
3. Is this condition getting worse? [ ] Yes [ ] No When this problem is at it's worst, how does it feel?______________

(please circle most accurate description of your complaint for numbers 4 – 9)

4. *Severity:*
   - Minimal – Annoyance – No impairment
   - Slight – Some mild impairment
   - Moderate – Marked impairment
   - Severe – Incapacitated/Bed ridden
   - 0 1 2 3 4 5 6 7 8 9 10
   - No Pain → Excruciating Pain

5. *Duration:*
   - Occasional [25% of the day]
   - Intermittent [25-50% of the day]
   - Frequent [50-75% of the day]
   - Constant [75-100% of the day]

6. *Character:*
   - Dull ache
   - Sharp / Stabbing
   - Burning
   - Throbbing
   - Radiating
   - Other:___________________________

7. *Relation to other body systems:*
   - Bowel / Bladder / Numbness / Tingling
   - Muscle weakness / Dizziness / Nausea
   - Vision / Digestion / Constipation / Diarrhea
   - Breathing / Fever / Chills / Chronic Infections
   - Weight loss / Other:______________________________

8. *Relieving Factors:* Rest / Exercise / Bracing / Taping / Sitting / Standing / Lying on back / Heat / Cold Pack / Other:____

9. *Aggravating Factors:* Cough / Sneeze / Bowel movement / Lifting / Bending / Push / Pull / Driving / Lying on back / Sitting / Walking / Running / Standing / Changing body positions / Other:____

How has this affected and/or restricted your life? Lack of energy / Stressed / Depressed / Family activities / Playing with children / Lifting / Sleep / Work / Sports / Hobbies / Household chores / Making bed / Yard work / Washing car / Reading / Driving / Carrying groceries / Sitting / Standing / Walking, etc. Explain:________________________________

____

Any family members with the same problem(s)?____

Other chiropractor / doctor seen for this reason? [ ] Yes [ ] No Who?________________________________

Date of last visit:__________

Type of treatment:_________________________________ Results:____________________________________

Any drugs (prescribed or over –the-counter) specifically for this complaint?__________________________

Do you suffer from any condition other than that which you are now consulting us for?_________________

Headaches: 1. *Duration:*_____________ 2. *Severity:* See above scale: [1 to 10] Worst headache in your life?

3. *Character:* Dull / Sharp Throbbing 4. *What brings them on:* Food(s) / Stress / Light / Fasting / Awakens sleep

5. *What aggravates them:* Exertion / Coughing / Bending / Sexual activity

6. What gives relief:____

7. How long have you had them:__________ 8. Any family members have same headaches: YES / NO

9. Are headaches often preceded by: Fatigue / Yawning / Sleepiness / Euphoria

10. Any Visual disturbances / Nausea / Vomiting / Pallor / Cold hands of feet / Seizure / Weakness or unusual sensations of the arms or legs / Unsteady gait / Slurred speech / Confusion / Fever / Stiff neck / Runny eyes or nose

11. Recent: Head trauma / Fall

GOALS

What current health goals do you want to achieve with regular chiropractic care, nutritional & fitness changes?

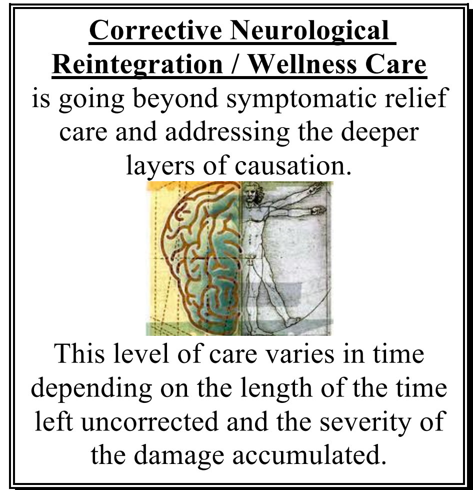
Chiropractic:____

____

Nutritional:____

Fitness:____

Why chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief care). Most often patients choose to have their symptoms relieved, correction of their cause of symptoms and then maintaining their body to the highest state of health possible by using regular chiropractic care to genuinely create wellness from within (Wellness Care). Your doctor will weigh your needs and desires when recommending your care program.



Please check the type of care desired so that we may be guided by your wishes whenever possible.
[ ] Symptomatic Relief Care **[ ] Corrective Neurological Reintegration / Wellness Care**

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT (unless other arrangements are made). We accept as payment all major credit cards, cash and checks.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Some companies pay fixed allowances for certain procedures and others pay a % of the charge. It is my responsibility to pay any deductible amount, co-payment, or any other balance not paid by my insurance company. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. A repeat billing charge of $10.00 will be added to all accounts 30 days old to defray our costs. We reserve the right to charge interest at 1 ½ % per month on balances 30 days and older. The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient or responsible party authorized by the patient to execute this agreement on behalf of the patient.

I hereby authorize the doctor to examine, take radiographs and care for me **(or for the above mentioned minor)** as he or she deems appropriate through use of spinal adjustments throughout my spine. The radiographic films will remain the property of this office, being on file for seven years where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature:____ Date:______________________
Guardian or Spouse's

Signature of authorizing care:______________________________________ Date:______________________

Relationship:____

Do Not Write Below This Line

Patient accepted: [ ] Yes [ ] No [ ] Refer out to / for:____

____
Doctor's signature