Confidential Patient Information

Welcome to Affinity Chiropractic

You are about to under go an extensive holistic health evaluation. Since we evaluate your structural, chemical, and mental health, the questions we ask are thorough and comprehensive. We will utilize the patient information forms you fill out, along with your history, lab work, and a chiropractic exam to properly evaluate your overall health. The doctor's findings from all the information will be presented at your report of findings during your second visit. Please take some time to complete this questionnaire. The questions in this questionnaire are comprehensive for overall health and wellness. We need this information in order to provide complete and total care.

We look forward to working with you and are privileged to help you achieve your health and wellness goals.

Name_____ Date____/____/_____

Personal Information

Date of Birth____/____/_____ Age_____ Social Security # _____-_____-_____

Address_____ Home Phone (____)_____

City_____ Cell Phone (____)_____

State_____ Zip_____ Email Address _____

Marital Status (circle one) S M W D Spouse's Name _____

Employment Information

Occupation_____ Occupation_____

Employer_____ Employer_____

Insurance Information (or bring a copy of your insurance card with you to your initial visit)

Do you have health insurance? ____Yes ____No Is your visit related to a work accident?___Yes ___No

Ins. Company_____ Have you reported it to your employer?___Yes ___No

Policy #_____ Is your visit related to an auto accident?___Yes ___No

Member #_____ If work/auto related: Date of Accident ___/___/_____

Health History

What is your major complaint?_____

How long have you had this condition? _____Years _____Months

Is this condition: _____Improved _____Unchanged _____Getting Worse

Please give brief history of this condition?_____

_____

Have you had this or similar conditions in the past? Please explain_____

Please lest any doctors or therapists who have treated this condition: (May I contact them for an update?) _Y _N

Have you ever been under Chiropractic Care? ___Yes ___No If yes, when?_____

What was the nature of your previous Chiropractic Treatment? _____

Pleases list your health goals that you would like to obtain by getting treated at Affinity Chiropractic.

1._____ 2._____

3._____ 4._____

Please rate the following by putting an X on the grid in the place that best describes you at this time:

Energy Level

[_____]

No Energy Most Energy Possible

If your energy is lower than desired, when is it typically decreased?

_____in the morning _____in the afternoon _____at night _____after meals

Current Health

[_____]

No Health As Healthy as Possible

What do you think is keeping you from being the healthiest you can be?_____

What do you believe you need to do to increase your health?_____

Stress Level

[_____]

No Stress Extremely Stressful

Please list the major stressors in your life:_____

Commitment to Health

[_____]

No Commitment As Committed as Possible

Please place a "C" next to any of the following symptoms/conditions that you are experiencing currently and a "P" next to any of the following symptoms/conditions you have experienced in the past.

General
___Headache
___Fever
___Chills
___Night sweats
___Fainting
___Anxiety
___Depression
___Loss of sleep
___Fatigue
___Nervousness
___Weight loss
___Allergies (list)
incontinence
_____
_____

Muscle/Joint/Nerve
___Neck Pain
___Back Pain
___Arm/Leg Pain
___Arm/Leg numbness
___Weakness
___Twitching
___Tremors
___Swollen joints
___Scoliosis
___Hernia
___Dizziness
___Convulsions

Gastro- intestinal
___Appetite changes
___Indigestion
___Excessive hunger
___Belching/Gas
___Nausea
___Vomiting
___Vomiting blood
___Abdominal pain
___Constipation
___Diarrhea
___Painful BM
___Hemorrhoids

___Liver disease
___Jaundice

Cardiovascular
___High Cholesterol
___Heart attack
___Chest pain
___Stroke
___Rapid heart rate
___Slow heart rate
___High blood pressure
___Low blood pressure
___Palpitations
___Varicose Veins
___Swollen ankles
___Poor circulation

Eye/Ear/Nose/Throat
___Poor vision
___Blurred vision
___Pain in eyes
___Difficulty Hearing
___Earache
___Ear ringing
___Ear discharges
___Nasal congestion
___Nose bleeds
___Sore throat
___Hoarseness
___Hay fever

___Itchy eyes
___Frequent colds
___Enlarged thyroid
___Tonsillitis
___Sinus pressure

Skin
___Acne
___Skin eruptions
___Itching
___Bruising easily
___Dry skin
___Hives
___Eczema
___Rash
___Sensitive skin

Respiratory
___Chronic cough
___Spitting blood
___Spitting phlegm
___Wheezing
___Shortness of breath
___Asthma

Genito-urinary
___Frequent urination
___Painful urination
___Blood in urine
___Urinary

___Difficulty Initiating

Women
___Painful periods
___Excessive flow
___Irregular cycle
___Hot flashes
___No Period
___Miscarriage
___Vaginal discharge
Last pap ___/___/___

Men
___Prostate trouble
___Erectile dysfunction
___Testicular pain

Exercise
☐None
☐Infrequent
☐Daily
☐Heavy

Work Activities
☐Sitting
☐Standing
☐Light Labor
☐Heavy labor

Social Habits
☐Smoking
☐Alcohol
☐Caffeine
☐High Stress

Packs/day_____
Drinks/week_____
Amount/day_____
Reason_____

	Yes	No	Don't Know
As a child:			
Were you a full term baby?	____	____	____
Were you breast fed?	____	____	____
Were you fully vaccinated?	____	____	____
Currently or in the past: (Use C for current and P for past)			
Have you been exposed to 2nd hand smoke regularly?	____	____	____
Have you had mercury amalgam fillings?	____	____	____
Have you received the annual flu shot?	____	____	____
Have you been sensitive to perfumes or fragrances?	____	____	____
Have you lived on a farm?	____	____	____
Have you had trouble sleeping?	____	____	____
Have symptoms immediately after eating?	____	____	____
Have symptoms 30-60 minutes after eating?	____	____	____
Do you crave certain foods?			
If so, which ones?	____	____	____
Do you have aversion to certain foods?			
If so, which ones?			

Current Supplements	Taken For	Please list any injuries and dates:	
_____	_____	_____	___/___/_____
_____	_____	_____	___/___/_____
Current Medications	**Taken For**	**Please list any surgeries and dates:**	
_____	_____	_____	___/___/_____
_____	_____	_____	___/___/_____

Previously, have you taken any of the following medications: Antibiotics, birth control pills, or steroids?___Yes___No

Please give drug name, time length, and reason for any of the above medications (to the best of your memory)?

Are you currently on any special diet (i.e. Diabetic, Vegan, South Beach, Atkins, ect.)?

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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 understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Affinity Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. By signing below I certify that the information above is complete and accurate to the best of knowledge

_____ ___/___/_____

Signature (Parent or guardian if patient is under 18 years of age) Date

Identi-T™ Stress Assessment

Name _____ **Age** _____ **Sex** _____ **Date**_____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I...

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath 0 1 2 3
8. Am constipated 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night 0 1 2 3
13. Have trouble falling asleep and staying asleep 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: _____

Section B:

1. Find myself worrying about things big and small 0 1 2 3
2. Feel like I can't stop worrying, even though I want to 0 1 2 3
3. Feel impulsive, pent up, and ready to explode 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful 0 1 2 3

Total points: _____

Section C:

1. Have muscle and joint pains 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
7. Use medications to manage pain 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches 0 1 2 3

Total points: _____

Section D:

1.	Have trouble organizing my thoughts	0	1	2	3
2.	Get easily distracted and lose focus	0	1	2	3
3.	Have difficulty making decisions and mistrust my judgment	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6.	Am forgetful	0	1	2	3
7.	Feel unsettled, restless, and anxious	0	1	2	3
8.	Wake up tired and unrefreshed	0	1	2	3
9.	Experience heartburn and indigestion	0	1	2	3
10.	Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1.	Feel tired for no apparent reason	0	1	2	3
2.	Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3.	Find it difficult to concentrate and complete tasks	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6.	Have little or no interest in sex	0	1	2	3
7.	Sweat spontaneously during the day	0	1	2	3
8.	Feel puffy and retain fluids	0	1	2	3
9.	Sleep more than nine hours a night	0	1	2	3
10.	Have poor muscle tone	0	1	2	3
11.	Have trouble losing weight	0	1	2	3
12.	Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13.	Have no energy and feel physically weak	0	1	2	3
14.	Am susceptible to colds and the flu	0	1	2	3
15.	Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B & C:** _____
Add points from sections C, D & E	**Total for C, D & E:** _____

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   _____
3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
_____	_____	_____
_____	_____	_____

CANCELLATION POLICY

Effective 4/12/2010

Our Cancellation policy is as follows: We are requiring that you give a 24-hour notice for all cancellations. If you cancel your appointment less than 24 hours prior to your appointment or you do not show, you will be charged the full amount of the appointment(s). Thank you in advance for your cooperation we appreciate your support.

Patient Name:_____

Patient signature:_____ **Date:** _____