Health History

Full Name _____ **Preferred name** _____

Home Street Address _____

City, State, Zip _____

Cell phone _____ **Home or Work** _____

Email _____ **# Children** _____ **Ages:** _____

Occupation _____ **Hours/day on computer** _____ **Hours/day sitting** __

Who can we thank for referring you to us? _____

Chief Complaint and Duration: List from most severe to least severe.

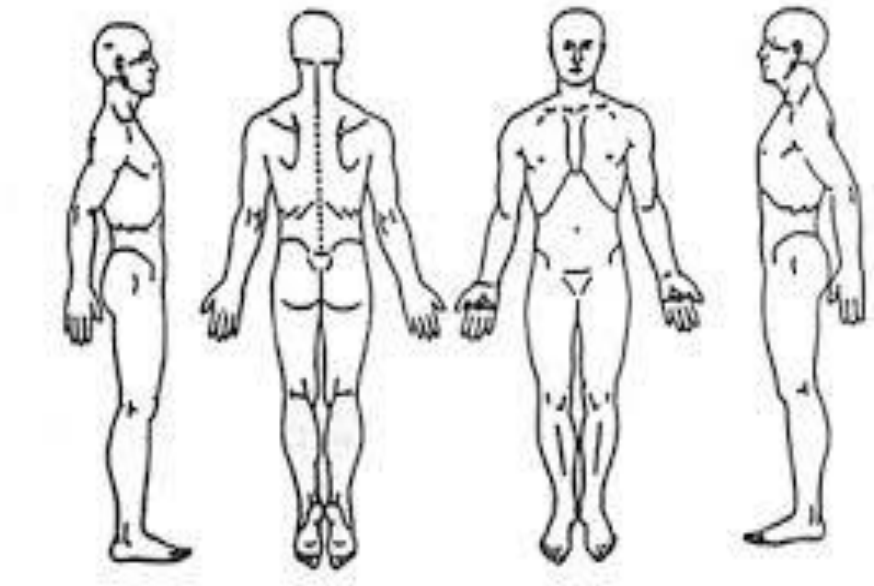
1._____ Date started_____

2._____ Date started_____

3._____ Date started_____

4._____ Date started_____

5._____ Date started_____



Please label area of discomfort/pain in the diagram above.

AAA=ache DDD=dull SSS=sharp +++=burning 000=constant TTT=tingling vvv=other_____

What have you done in order to alleviate your condition?

_____

Name_____

Are activities you do being affected by your condition? Check those that apply.

( ) Job	( ) Hobbies	( ) Sports	( ) Walking
( ) Children	( ) Exercise	( ) Standing	( ) Sitting
( ) Sleeping	( ) Lying Down	( ) Productivity	( ) Energy
( ) Fatigue	( ) Urinary	( ) Bowels	( ) Concentration
( ) Studying	( ) School	( ) Digestion	

( ) Other:_____

Please give most current date:

( ) _____ Spinal Exam ( ) _____ Disc Exam ( ) _____ X-ray Exam
( ) _____ Physical ( ) _____ Pap Smear ( ) _____ Breast Exam

Do you have any known allergies_____

Female: ( ) Not currently pregnant ( ) Currently pregnant or planning

Family History:

	Diabetes	Heart	Kidney	Cancer	Weight	Other
Mother	( )	( )	( )	( )	( )	( )_____
Father	( )	( )	( )	( )	( )	( )_____
Brother	( )	( )	( )	( )	( )	( )_____
Sister	( )	( )	( )	( )	( )	( )_____

Please list your current doctors:

1._____ 2. _____

3._____ 4. _____

Please list your current; Medications, Vitamins, Homeopathics, …

1_____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

7._____ 8. _____ 9. _____

Please list past accidents and injuries you have sustained:

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

Have you ever been hospitalized: ( ) YES ( ) NO

_____

_____

Name_____

Have you ever had any surgeries? ( ) YES ( ) NO

_____

_____

Have you or a family member ever had a mental disorder? ( ) YES ( ) NO

_____

Have you ever broken a bone? ( ) YES ( ) NO _____

Have you ever been treated by a chiropractor? ( ) YES ( ) NO _____

Please check all that apply:

General Symptoms:

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Insomnia
- ☐ Fatigue
- ☐ Nervousness
- ☐ Loss of Weight
- ☐ Allergy
- ☐ Wheezing
- ☐ Neuralgia,
- ☐ Numbness/Pain: arms, hands, legs

Head or Neck Trauma:

- ☐ Concussion
- ☐ "TBI" Traumatic Brain Injury
- ☐ Unconsciousness

Respiration:

- ☐ Chronic cough
- ☐ Spitting up phlegm / blood
- ☐ Difficult breathing
- ☐ Chest pain

Skin:

- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruising
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Hives
- ☐ Allergies

Name_____

E.E.N.T.:

- ☐ Failing vision
- ☐ Near sightedness
- ☐ Far sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Ear noise
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Hay fever
- ☐ Asthma
- ☐ Dental decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Tonsillitis
- ☐ Enlarged thyroid
- ☐ Sinus infections
- ☐ Nasal drainage
- ☐ Enlarged glands

Cardiovascular:

- ☐ Rapid / Slow beating heart
- ☐ High / Low blood pressure
- ☐ Pain over heart
- ☐ Previous Heart / Stroke
- ☐ Hardening of Arteries
- ☐ Swelling of Ankles
- ☐ Poor circulation

Muscle and Joint Symptoms:

- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Joints feel hot
- ☐ Tremors,
- ☐ Foot Trouble
- ☐ Painful tailbone
- ☐ Pain between shoulders
- ☐ Hernia
- ☐ Spinal curvature

Genitourinary Symptoms:

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Bloody urine
- ☐ Pus in urine
- ☐ Kidney Infections / Stones
- ☐ Bed wetting
- ☐ Prostate trouble
- ☐ Inability to control urine

Name_____

Gastrointestinal System:

- ☐ Appetite Excessive / Poor
- ☐ Difficult digestion
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Pain over stomach
- ☐ Distension of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Jaundice
- ☐ Gallbladder trouble
- ☐ Colitis
- ☐ Gastric reflux

Females:

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycles
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Congested breast
- ☐ Lumps in breast
- ☐ Menopausal symptoms

Bowels move: ( )1 time or less per day, ( ) 2-3 times per day, ( ) 4 or more times per day

Travel: Have you travel out of country? ( ) YES ( ) NO _____

Do you have: Surgical staples, Pacemaker, Shunts. Other hardware/electronics:_____

Do you have:

- ☐ Heel lift
- ☐ Orthotics
- ☐ Arch supports
- ☐ Other_____

Doctors Signature_____ Date_____

HIPPA Agreement Consent for treatment, Payment and Healthcare Operations

I, _____ consent to the use of my Protected Health Information (PHI) by Dr. Troy Hagen, and/or staff of Birmingham Wellness LLC, d/b/a Greystone Chiropractic or (hereafter "the practice"), for the purpose of providing treatment for me, for purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations. Healthcare operations may include, but are not limited to: quality assessment activities, credentialing, business management, or general operational activities. I understand the practice's diagnosis, treatment plan, and other evaluation and management information may be conditioned upon by consent as evidenced by my signature on this document.

For purposes of consent, PHI means any information, including demographic information, created or received by the practice, that relates to my past, present or future physical or mental health or condition; the provision of healthcare to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment, or healthcare operations of the practice, but the practice is not required to agree to these restrictions. However, if the practice agrees to the restriction that I request, the restriction is binding on the practice until which time I remove the restriction in writing.

I understand that I have the right to review the practice's notice of privacy practices prior to signing this document. The notice of privacy practices describes my rights and the practice's duties regarding the types of uses and disclosures of my PHI. I have the right to revoke this consent, in writing, at any time, except to the extent that physician or the practice has acted in reliance on this consent.

Patient signature Printed name Date

Informed Patient Consent & the Doctor-Patient Relationship

Chiropractic Care

It is the premise of chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis (balance and regulation). This allows the body to establish normal function, express appropriate adaptation as needed, and employ its recuperative, health-sustaining powers. The relationship between the spine and nervous system may affect the conduction of nerve impulses affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment, this allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes, and the physical and spinal conditions of each individual patient.

Chiropractic Analysis

The doctor will conduct a clinical analysis for the express purpose of detecting the presence of vertebral subluxation/s and the effects of those misalignments. If not detected, and the patient is in need of care from another provider, the patient will be informed and referred for other appropriate care.

Clinical Results

The purpose of chiropractic care is to promote health and vitality through the correction of the vertebral subluxation complex. Since there are many variables in health care, it is difficult to predict the timing, degree of response to care, and efficacy of chiropractic care for any given patient. However, the doctor may make recommendations for clinical management based on known circumstances and clinical experience. Due to complexities of nature, and the many variables, both known and unknown, that can affect patient response to care, no doctor can promise specific results. The doctor of chiropractic (DC) is licensed to provide a specialized, unique, non-duplicating health service. The chiropractor is licensed in a special area of practice and is available to work alongside other providers in your health care regimen.

Medical Diagnosis

Although doctors of chiropractic are experts in the analysis of the structural alignment of the spine and body and its effects on the nervous system, they are not medical doctors, internists, or surgical specialists. Therefore, every patient should be mindful of their own condition/s and should secure other opinions should they have concerns as to the nature of any other symptoms or their total health picture. Your doctor of chiropractic may express an opinion as to whether or not further consult is necessary, but the patient is responsible for the final decision and any subsequent action.

Contraindications to Chiropractic Care

Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes adverse reactions. In rare cases, however, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures, or disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contraindicated. It is the responsibly of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of the doctor.

By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for then in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures.

Patient Consent

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care. I have read and understand the Informed Patient Consent and Doctor Patient Relationship. I hereby request and authorize the doctor to render chiropractic evaluation, and care if necessary.

Patient signature (or guardian) Printed name Date