Welcome to Giesen Family Chiropractic!

Patient Health Record

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

About the Patient

Name_____ Birth Date _____ Age _____

Address _____ City, State, Zip_____

Home Phone _____ Cell_____ Number of Children _____

Email Address_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer_____ Type of work _____

Work Address_____

Work Phone_____

About the Spouse (if applicable)

Name _____ Employer _____

Work Phone _____ Type of work _____

In an Emergency, Contact:

Name_____ Relationship_____

Work Phone_____ Home Phone_____

Cell Phone_____

Reason for The Visit

Describe the purpose of this visit_____

_____

Is the purpose of this appointment related to ☐ Work ☐ Auto Accident

If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

When did this condition begin?_____

Has this condition ☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other activities

Explain_____

Has this condition occurred before? ☐ Yes ☐ No

Explain_____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Dr.'s Name (s)_____

Type of Treatment_____

Results_____

Experience with Chiropractic

Whom may we thank for referring you to this office?_____

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits?_____

Doctor's Name_____

Approximate date of last visit_____

Has any *adult* in your family seen a Chiropractor? ☐ Yes ☐ No

Has any *child* in your family seen a Chiropractor? ☐ Yes ☐ No

Awareness of Chiropractic Principles

Were you aware that

- …Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No
- …the nervous system controls all bodily functions and systems? ☐ Yes ☐ No
- …Chiropractic is the largest natural healing professional in the world? ☐ Yes ☐ No
- …if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No
- …research shows that many of the health challenges that occur later in life have their origins during birth and the developmental years? ☐ Yes ☐ No

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your care plan. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care** – Symptomatic relief of pain of discomfort

☐ **Corrective Care** - Correcting and relieving the cause of the problem as well as the symptoms

☐ **Wellness Care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ I want the Doctor to select the type of care appropriate for my condition.

Health Conditions

Please **circle** all conditions you are experiencing, even if they seem unrelated to the purpose of this visit. Please put an **(x)** by all the conditions you have previously experienced.

NMS

- ☐ Headaches
- ☐ Neck Stiffness
- ☐ Pins/Needles in arms
- ☐ TMJ/Jaw Pain
- ☐ Pain between the Shoulders
- ☐ Neck Pain
- ☐ Numbness/Pain in Arms/Hand
- ☐ Low Back Pain
- ☐ Numbness/pain in Legs/Feet
- ☐ Pins/Needles in Legs/Feet
- ☐ Arthritis
- ☐ Disc herniation
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis

Visceral

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Excessive Thirst
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High/Low Blood Pressure
- ☐ Acid Reflux/Heartburn
- ☐ Lung Problems
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Weight Loss
- ☐ Loss of appetite
- ☐ Upset Stomach
- ☐ Ulcers
- ☐ Diabetes
- ☐ Anemia
- ☐ Difficult urination
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Irritable Bowel
- ☐ Hemorrhoids
- ☐ Prostate Problems
- ☐ Infertility
- ☐ Fever
- ☐ Liver Disease
- ☐ Kidney Problems

Other

- ☐ Cancer
- ☐ Loss of Sleep
- ☐ Oversleeping
- ☐ Low Energy
- ☐ Confusion
- ☐ Mood Swings
- ☐ Depression
- ☐ Irritability
- ☐ Nervousness
- ☐ Anxiety

Special Senses

- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Dizziness
- ☐ Epilepsy

Female

- ☐ Pregnancy
- ☐ Nursing
- ☐ Difficult getting pregnant
- ☐ Miscarriage
- ☐ Menstrual Pain
- ☐ Menstrual Irregularities
- ☐ Hot Flashes
- ☐ Other _____

_____

_____

Medications I Now Take

☐ Nerve Pills ☐ Stimulants ☐ Pain Killers (including Aspirin)

☐ Blood Thinners ☐ Muscle Relaxers ☐ Tranquilizers

☐ Blood Pressure Medicine ☐ _____

☐ Insulin ☐ _____

Health Habits

	No	Yes	
Do you smoke?	☐	☐	_____packs/day
Do you drink alcohol?	☐	☐	_____drinks/day
Do you drink coffee?	☐	☐	_____drinks/day

Do you exercise regularly? ☐ No ☐ Moderate ☐ Daily

Do you use: ☐ Heel lifts ☐ Inner Soles ☐ Arch Supports

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as she deems appropriate.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am 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. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services.

_____

Patient's Signature Date

_____

Guardian or Spouse's Signature Authorizing Care Date

We are happy to bill your insurance as a courtesy. It is your responsibility to know the limits of your insurance policy and you are responsible for any balance not covered by insurance.
****There is a $20 fee for missed appointments***

Ownership of X-ray Films.

I understand and agree that all the payments to the Doctors X-rays is for examination only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.