



# CONFIDENTIAL HEALTH INFORMATION

Inspired Health Chiropractic & Wellness  
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Please allow our staff to photocopy your driver's license and insurance details.  
All information you supply is confidential. We comply with all federal privacy standards.  
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No  Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

Male  Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

Single  Married  Divorced

Widowed  Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes  No

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: \_\_\_\_\_

Patient name \_\_\_\_\_

2. And are the result of (darken circle):  An accident or injury  
 Work  Auto  Other \_\_\_\_\_  
 A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

3. Onset (When did you first notice your current symptoms?) \_\_\_\_\_

4. Intensity (How extreme are your current symptoms?)



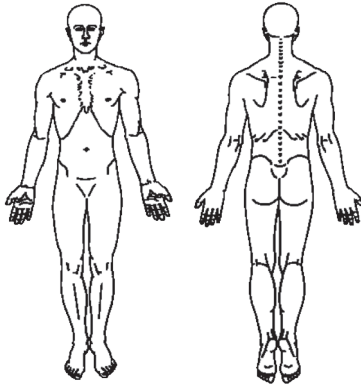
5. Duration and Timing (When did it start and how often do you feel it?)

Constant  Comes and goes. How Often? \_\_\_\_\_

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other \_\_\_\_\_

7. Location (Where does it hurt?) Circle the area(s) on the illustration. "0" for current condition "X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) \_\_\_\_\_

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? \_\_\_\_\_

What tends to lessen the problem? \_\_\_\_\_

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication  Surgery  Ice
- Over-the-counter drugs  Acupuncture  Heat
- Homeopathic remedies  Chiropractic  Other \_\_\_\_\_
- Physical therapy  Massage \_\_\_\_\_

11. What else should Dr. Loda know about your current condition? \_\_\_\_\_

12. How does your current condition interfere with your:

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

Personal relationships: \_\_\_\_\_

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have   Osteoporosis   Arthritis   Scoliosis   Neck pain   Back problems   Hip disorders   NONE   
  Knee injuries   Foot/ankle pain   Shoulder problems   Elbow/wrist pain   TMJ issues   Poor posture Initials \_\_\_\_\_

b. Neurological

Had Have   Anxiety   Depression   Headache   Dizziness   Pins and needles   Numbness   NONE   
Initials \_\_\_\_\_

c. Cardiovascular

Had Have   High blood pressure   Low blood pressure   High cholesterol   Poor circulation   Angina   Excessive bruising   NONE   
Initials \_\_\_\_\_

d. Respiratory

Had Have   Asthma   Apnea   Emphysema   Hay fever   Shortness of breath   Pneumonia   NONE   
Initials \_\_\_\_\_

e. Digestive

Had Have   Anorexia/bulimia   Ulcer   Food sensitivities   Heartburn   Constipation   Diarrhea   NONE   
Initials \_\_\_\_\_

f. Sensory

Had Have   Blurred vision   Ringing in ears   Hearing loss   Chronic ear infection   Loss of smell   Loss of taste   NONE   
Initials \_\_\_\_\_

g. Integumentary

Had Have   Skin cancer   Psoriasis   Eczema   Acne   Hair loss   Rash   NONE   
Initials \_\_\_\_\_

Consultation Notes

Doctor's Initials \_\_\_\_\_

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**21. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name \_\_\_\_\_

22. What is the major stressor in your life? \_\_\_\_\_ 23. How much sleep do you average per night? \_\_\_\_\_ Hours

24. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 25. What is your preferred sleeping position? \_\_\_\_\_

26. Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals

27. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

28. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

Consultation Notes

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials \_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials \_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_

Initials \_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials \_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials \_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: \_\_\_\_\_

Doctor's Initials \_\_\_\_\_

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Signature \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_