



CONFIDENTIAL HEALTH INFORMATION

Inspired Health Chiropractic & Wellness

Dr. Jessica Loda

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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?

Patient Number (office use only)

No Yes

Whom may we thank for referring you?

When?

If so, whom?

Age

Gender

Male Female

Non-Binary

Race

American Indian Alaskan Native Asian Black or African American
 Native Hawaiian Other Pacific Islander Other White
 Decline to answer

Ethnicity

Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status Married

Single Divorced

Widowed Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

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

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

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

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

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

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

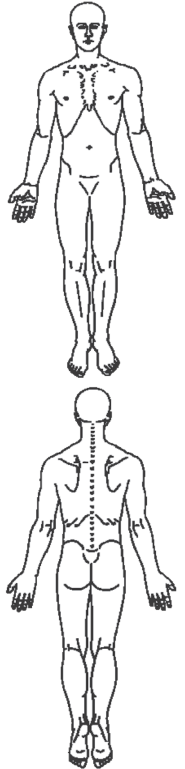
- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

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

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

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



1. What else should Dr. Loda know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. 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 <input type="radio"/> Have <input type="radio"/> Osteoporosis | Had <input type="radio"/> Have <input type="radio"/> Arthritis | Had <input type="radio"/> Have <input type="radio"/> Scoliosis | Had <input type="radio"/> Have <input type="radio"/> Neck pain | Had <input type="radio"/> Have <input type="radio"/> Back problems | Had <input type="radio"/> Have <input type="radio"/> Hip disorders | NONE <input type="radio"/> |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | Initials _____ |

b. Neurological

- | | | | | | | |
|--|---|---|--|---|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Anxiety | Had <input type="radio"/> Have <input type="radio"/> Depression | Had <input type="radio"/> Have <input type="radio"/> Headache | Had <input type="radio"/> Have <input type="radio"/> Dizziness | Had <input type="radio"/> Have <input type="radio"/> Pins and needles | Had <input type="radio"/> Have <input type="radio"/> Numbness | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

c. Cardiovascular

- | | | | | | | |
|--|---|---|---|---|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> High blood pressure | Had <input type="radio"/> Have <input type="radio"/> Low blood pressure | Had <input type="radio"/> Have <input type="radio"/> High cholesterol | Had <input type="radio"/> Have <input type="radio"/> Poor circulation | Had <input type="radio"/> Have <input type="radio"/> Angina | Had <input type="radio"/> Have <input type="radio"/> Excessive bruising | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

d. Respiratory

- | | | | | | | |
|---|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Asthma | Had <input type="radio"/> Have <input type="radio"/> Apnea | Had <input type="radio"/> Have <input type="radio"/> Emphysema | Had <input type="radio"/> Have <input type="radio"/> Hay fever | Had <input type="radio"/> Have <input type="radio"/> Shortness of breath | Had <input type="radio"/> Have <input type="radio"/> Pneumonia | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

e. Digestive

- | | | | | | | |
|---|--|---|--|---|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Anorexia/bulimia | Had <input type="radio"/> Have <input type="radio"/> Ulcer | Had <input type="radio"/> Have <input type="radio"/> Food sensitivities | Had <input type="radio"/> Have <input type="radio"/> Heartburn | Had <input type="radio"/> Have <input type="radio"/> Constipation | Had <input type="radio"/> Have <input type="radio"/> Diarrhea | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

f. Sensory

- | | | | | | | |
|---|--|---|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Blurred vision | Had <input type="radio"/> Have <input type="radio"/> Ringing in ears | Had <input type="radio"/> Have <input type="radio"/> Hearing loss | Had <input type="radio"/> Have <input type="radio"/> Chronic ear infection | Had <input type="radio"/> Have <input type="radio"/> Loss of smell | Had <input type="radio"/> Have <input type="radio"/> Loss of taste | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

g. Skin

- | | | | | | | |
|--|--|---|---|--|---|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> Skin cancer | Had <input type="radio"/> Have <input type="radio"/> Psoriasis | Had <input type="radio"/> Have <input type="radio"/> Eczema | Had <input type="radio"/> Have <input type="radio"/> Acne | Had <input type="radio"/> Have <input type="radio"/> Hair loss | Had <input type="radio"/> Have <input type="radio"/> Rash | NONE <input type="radio"/> |
| | | | | | | Initials _____ |

Patient name

Patient Number
(office use only)

Doctor's Initials

Inspired Health
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(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

Initials _____

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

Initials _____

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE

Initials _____

Patient name _____
 Patient Number (office use only) _____
 All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

| | | | |
|---|--|---|---|
| PERSONAL | 4. Illnesses Check the illnesses you have Had in the past or Have now. | 5. Operations Surgical interventions, which may or may not have included hospitalization. | 6. Treatments Check the ones you've received in the Past or are receiving Currently . |
| | Had <input type="radio"/> Have <input type="radio"/> AIDS | Had <input type="radio"/> Have <input type="radio"/> Tuberculosis | Past <input type="radio"/> Currently <input type="radio"/> Acupuncture |
| | Had <input type="radio"/> Have <input type="radio"/> Alcoholism | Had <input type="radio"/> Have <input type="radio"/> Typhoid fever | <input type="radio"/> Antibiotics |
| | Had <input type="radio"/> Have <input type="radio"/> Allergies | Had <input type="radio"/> Have <input type="radio"/> Ulcer | <input type="radio"/> Birth control pills |
| | Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis | Had <input type="radio"/> Have <input type="radio"/> Other: _____ | <input type="radio"/> Blood transfusions |
| | Had <input type="radio"/> Have <input type="radio"/> Cancer | | <input type="radio"/> Chemotherapy |
| | Had <input type="radio"/> Have <input type="radio"/> Chicken pox | | <input type="radio"/> Chiropractic care |
| | Had <input type="radio"/> Have <input type="radio"/> Diabetes | 7. Allergies Are you allergic to any medications? | <input type="radio"/> Dialysis |
| | Had <input type="radio"/> Have <input type="radio"/> Epilepsy | Yes <input type="radio"/> No <input type="radio"/> If Yes please list: _____ | <input type="radio"/> Herbs |
| | Had <input type="radio"/> Have <input type="radio"/> Glaucoma | | <input type="radio"/> Homeopathy |
| | Had <input type="radio"/> Have <input type="radio"/> Goiter | | <input type="radio"/> Hormone replacement |
| | Had <input type="radio"/> Have <input type="radio"/> Gout | | <input type="radio"/> Inhaler |
| | Had <input type="radio"/> Have <input type="radio"/> Heart disease | | <input type="radio"/> Massage therapy |
| | Had <input type="radio"/> Have <input type="radio"/> Hepatitis | | <input type="radio"/> Physical therapy |
| | Had <input type="radio"/> Have <input type="radio"/> HIV Positive | | <input type="radio"/> Medications |
| Had <input type="radio"/> Have <input type="radio"/> Malaria | | <small>(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):</small> | |
| Had <input type="radio"/> Have <input type="radio"/> Measles | | _____ | |
| Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis | | _____ | |
| Had <input type="radio"/> Have <input type="radio"/> Mumps | | _____ | |
| Had <input type="radio"/> Have <input type="radio"/> Polio | 8. Injuries Have you ever... | _____ | |
| Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever | <input type="radio"/> Had a fractured or broken bone | <input type="radio"/> Used a crutch or other support | |
| Had <input type="radio"/> Have <input type="radio"/> Scarlet fever | <input type="radio"/> Had a spine or nerve disorder | <input type="radio"/> Used neck or back bracing | |
| Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease | <input type="radio"/> Been knocked unconscious | <input type="radio"/> Received a tattoo | |
| Had <input type="radio"/> Have <input type="radio"/> Stroke | <input type="radio"/> Been injured in an accident | <input type="radio"/> Had a body piercing | |

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Loda about the health of your immediate family members.

| FAMILY | Relative | Age (If living) | State of health | | Illnesses | Age at death | Cause of death | |
|--------|-----------|-----------------|-----------------------|-----------------------|-----------|--------------|-----------------------|-----------------------|
| | | | Good | Poor | | | Natural | Illness |
| | | | <input type="radio"/> | <input type="radio"/> | | | <input type="radio"/> | <input type="radio"/> |
| | Mother | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |
| | Father | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |
| | Sister 1 | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |
| | Sister 2 | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |
| | Brother 1 | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |
| | Brother 2 | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |
| | _____ | _____ | <input type="radio"/> | <input type="radio"/> | _____ | _____ | <input type="radio"/> | <input type="radio"/> |

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Loda about your health habits and stress levels.

| | | | | | |
|---------------|----------------|--|-----------------|-----------------------|--|
| SOCIAL | Alcohol use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Prayer or meditation? | <input type="radio"/> Yes <input type="radio"/> No |
| | Coffee use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Job pressure/stress? | <input type="radio"/> Yes <input type="radio"/> No |
| | Tobacco use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Financial peace? | <input type="radio"/> Yes <input type="radio"/> No |
| | Exercising | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Vaccinated? | <input type="radio"/> Yes <input type="radio"/> No |
| | Pain relievers | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Mercury fillings? | <input type="radio"/> Yes <input type="radio"/> No |
| | Soft drinks | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Recreational drugs? | <input type="radio"/> Yes <input type="radio"/> No |
| | Water intake | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | | |
| | Hobbies: | _____ | | | |

Doctor's Initials _____
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12. 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 _____

Patient Number
(office use only)

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

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

18. What would be the most significant thing that you could do to improve your health? _____

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

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.**

Consultation Notes

Doctor's Initials _____

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Chiropractic & Wellness

Patient (or Guardian's) signature

Date (MM/DD/YYYY)