ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email _____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

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

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-_____ **Relation To You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

ID/Policy Number _____ **Group Number** _____

Insured's Name _____ **Insured's Date of Birth** ____ / ____ / _____

REFERRAL INFORMATION.

Referring Physician _____ **Contact information.** _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

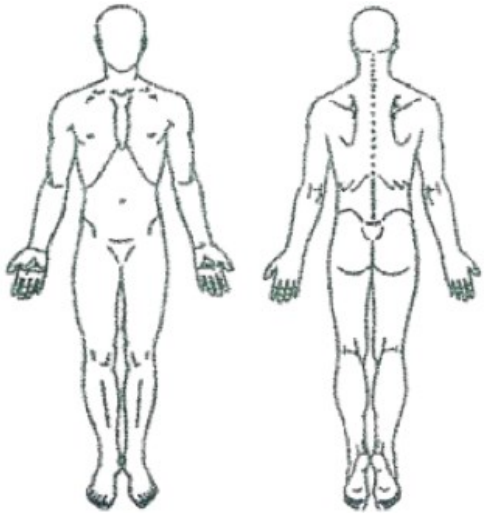
What caused this condition _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None										*Unbearable*
0	1	2	3	4	5	6	7	8	9	10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment, if any, have you received since the injury? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Do you have any medication allergies?	☐ No	☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

MEN'S HEALTH

Do you have pain or lump in scrotum or testicles?

☐ Yes ☐ No

Do you have an impaired libido (sex drive)?

☐ Yes ☐ No

Do you have discharge from your penis?

☐ Yes ☐ No

Do you have prostate issues?

☐ Yes ☐ No

When was your last prostate exam?

☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a prostate exam
☐ Prefers not to answer or don't know

When was your most recent PSA (Prostate-Specific Antigen) blood test?

☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a PSA blood test
☐ Prefers not to answer or don't know

What was your PSA (Prostate-Specific Antigen) level on your latest test?

☐ Normal or low ☐ Moderate
☐ High ☐ Never had a PSA level done
☐ Prefers not to answer or don't know

WOMEN'S HEALTH

Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform a regular self-breast examination?	☐ Yes ☐ No
Do you take hormone replacement therapy (HRT)?	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know
	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

The Nature of Chiropractic Treatment: Chiropractic adjustments as they are performed in this office are typically hands on procedures designed to restore the bio-mechanical integrity of the spine. Occasionally a mechanical device may be used to provide an adjustment. You may feel or hear a "click" or "pop", such as the noise made when a knuckle is cracked, and you may feel movement of the joint.

Possible Risks: Occasionally stiffness, soreness and/or headache may occur following an adjustment. Adjustments are generally safe with a very low risk of side effects or negative results. However as with any health care procedure, there are potential risks associated with treatment.

Potential risks could include: muscle and ligament strain/sprain, fracture, joint dislocation, inter-vertebral disc injury, and stroke. These risks are most often associated with the presence of underlying physical defects, deformities or pathologies that render the patient susceptible to injury. It is the responsibility of the patient to make it known whether he/she is suffering from latent pathological defects, deformity, illness or symptoms that would otherwise not come to our attention.

Throughout the course of care the safety and appropriateness of chiropractic adjustments will be assessed. If we encounter non-chiropractic or unusual findings, we will advise you and will recommend that you seek the services of a provider who specializes in that area.

Results: Individual response to treatment may vary. While the vast majority of patients experience exceptional results through the use of our services, we cannot guarantee results. Your response to treatment will depend upon many factors including but not limited to the length of time the condition has been present, your adherence to the recommended treatment plan, and your actions and activities between office visits.

I have read and understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I hereby request and consent to treatment by Dr. Karel Lloyd and/or any other licensed doctor providing services for Clayton Chiropractic and intend this consent form to cover any current or future treatment received in this office.

Patient Signature: _____ **Date:** ____ / ____ / _____