

## ABOUT YOU

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mobile Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Home Phone \_\_\_\_-\_\_\_\_-\_\_\_\_

Email Address \_\_\_\_\_

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 \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## REFERRAL INFORMATION

Referring Physician \_\_\_\_\_ Contact Info \_\_\_\_\_

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 terms describe your discomfort best? (aching, burning, tingling, etc.)

\_\_\_\_\_

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 would you rate your current level of discomfort?

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

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 have you received for this condition up to now?

\_\_\_\_\_  
\_\_\_\_\_

**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:** \_\_\_\_\_

**Allergies or Sensitivities**  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 there any past illnesses or conditions we should be aware of?  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 AND SOCIAL HABITS

Current work habits: select 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: select all that apply

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

Present exercise habits: select all that apply

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

Diet and nutrition habits: select all that apply

- Vegan or vegetarian
- Daily supplements
- Other

## ADULT MEN'S HEALTH

**Do you have pain or a lump in your scrotum or testicles?**  Yes  No

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**Do you have an impaired libido (sex drive)?**  Yes  No

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**Do you have discharge from your penis?**  Yes  No

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**Do you have prostate issues?**  Yes  No

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**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

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**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

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**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

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## ADULT 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?  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

When was your last mammogram?  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.

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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