Bettendorf
Chiropractic Wellness Center

Minor New Patient Health History Form

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Patient Data

First Name:_____ MI: ___ Last Name: _____ Today's Date: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Ph: _____ Work Ph:_____

Email: _____

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements or promotions.

Birth Date: _____ Social Security #: _____ Number of Children: _____

Marital Status: _____Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Spouses Name: _____ Spouse Birth Date: _____

How were you referred? _____

Current Problem

Nature of Injury: Automobile _____ Work _____ Other _____

Date symptoms appeared: _____ Date of Injury: _____

Describe Symptoms: _____

_____

Pain scale (circle): 0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain**

What activities of daily living are affected? _____

_____

For the following questions circle what is true for your condition

Have you ever had the same condition? **NO** **YES** If yes, when? _____

Does the pain radiate into your: **Arm** **Leg** **Doesn't radiate** Do you experience numbness or tingling? **NO** **YES**

Have you ever been under chiropractic care? **NO** **YES** Did the pain come on **Gradually** or **Suddenly**?

Does your pain wake you at night? **NO** **YES** What percentage of the day is your pain present? (0-100%) _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Previous treatments for this condition, including self-treatment?_____

Social History:

Do you smoke? **YES** **NO** How much? _____ How long? _____

How much caffeine beverages in a day? _____ How much alcohol do you consume in a week? _____

Do you exercise? **YES** **NO** How much? **LIGHT** **MODERATE** **HEAVY**

Has your weight changed in the past year? **Yes** **No** How many hours of sleep do you get a night? _____

How much water do you drink a day? _____

Circle "Had" or " Have" on what is applicable for you:

Musculoskeletal:

Had Have **Neck Pain**
Had Have **Back Pain**
Had Have **Hip/knee Pain**
Had Have **Leg cramps**
Had Have **Arm/Hand Pain**
Had Have **Shoulder Pain**
Had Have **Swelling of Joints**
Had Have **Osteoporosis**
Had Have **Scoliosis**
Had Have **TMJ issues**

Neurological:

Had Have **Tremors**
Had Have **Dizziness/Fainting**
Had Have **Stress**
Had Have **Anxiety**
Had Have **Depression**
Had Have **Headache**
Had Have **Numbness/Tingling**
Had Have **Memory confusion**
Had Have **Seizures**
Had Have **Weakness**

Urinary:

Had Have **Pain with urination**
Had Have **Difficulty urinating**
Had Have **Frequent Urinary Tract Infect.**
Had Have **Blood in urine**
Had Have **Incontinence**
Had Have **Kidney infections**
Had Have **Urgency to urinate**
Had Have **Water retention**
Had Have **Bedwetting**
Had Have **Kidney Stones**

Gastrointestinal:

Had Have **Changes in bowel habits**
Had Have **Changes in appetite**
Had Have **Nausea**
Had Have **Heartburn**
Had Have **Diarrhea**
Had Have **Constipation**
Had Have **Anorexia/Bulimia**

Cardiovascular:

Had Have **High Cholesterol**
Had Have **High Blood pressure**
Had Have **Low blood pressure**
Had Have **Emphysema**
Had Have **Pneumonia**
Had Have **Swelling**
Had Have **Chest pain/Pressure**
Had Have **Excessive coughing**
Had Have **Difficulty breathing**
Had Have **Irregular Heartbeat/Palpit.**
Had Have **Shortness of breath**
Had Have **Wheezing**
Had Have **Asthma**
Had Have **Coughing up blood**

Endocrine:

Had Have **Thyroid issues**
Had Have **Low energy**
Had Have **Immune disorders**
Had Have **Excessive Thirst**
Had Have **Frequent urination**
Had Have **Swollen glands**
Had Have **Frequent Sweating**
Had Have **Dry Skin**

Eyes:

Had Have **Blurred vision or Double vision**
Had Have **Cataracts**
Had Have **Dryness in eyes**
Had Have **Glasses or contacts**
Had Have **Glaucoma**
Had Have **Eye pain**
Had Have **Itchy eyes**

Integumentary/Skin:

Had Have **Skin Cancer**
Had Have **Psoriasis**
Had Have **Eczema**
Had Have **Acne**
Had Have **Rash**
Had Have **Hair Loss**

Ears:

Had Have **Hearing Loss**
Had Have **Ringing in the Ears**
Had Have **Chronic Ear infections**
Had Have **Poor Balance**

Nose:

Had Have **Loss of smell**
Had Have **Allergies**
Had Have **Sinus pressure or pain**
Had Have **Nose bleeds**
Had Have **Blocked sinuses**

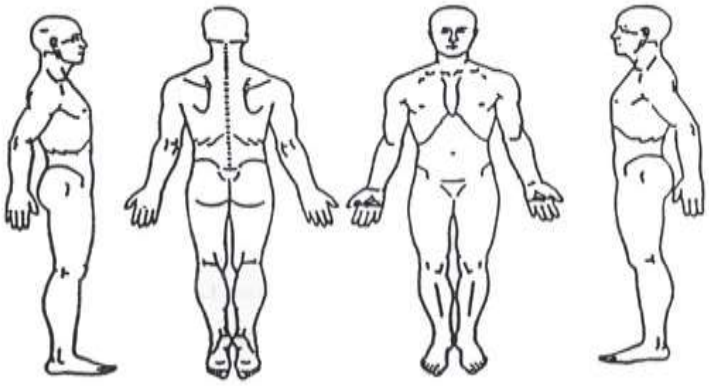
Females/Males:

Had Have **Infertility**
Had Have **Irregular cycles**
Had Have **Prostate problems**
Had Have **Low Sex Drive**
Had Have **Erectile Dysfunction**
Had Have **Hernia**

Other: _____

_____

MARK AREAS OF CONCERN:



In order to provide you the best possible wellness care, please complete the form.
All information is strictly CONFIDENTAL.

Medical History

Have you been treated for any conditions in the last year? **NO** **YES**

If yes, please describe _____

Date of last physical exam and Doctor_____

Women: Is there a chance that you are pregnant? **NO** **YES** Date of Last Menses: _____

Have you had X-rays or a MRI taken? **NO** **YES** If yes, where & when?

_____

	No	Yes	Explain:
Medications			
Allergies			
Auto Accidents			
Surgeries			
Traumas			
Any other Problems			

Family History

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Family Member: (ie. mother, father) Condition:

_____ _____

_____ _____

_____ _____

I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to the rendering physician for services rendered.

Signature:_____ Date: _____

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Informed Consent for Care

You are the decision maker for the health care of your child. This informed consent involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, the potential effect on your child's health if you choose not to receive the care and any of the fees for the services being provided to your child by Bettendorf Chiropractic Wellness Center.

Chiropractic care involves what is known as a chiropractic adjustment and possible additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing pain, swelling and inflammation in a joint, and improving neurological function and overall well-being. We may conduct chiropractic, physiotherapy, acupuncture, diagnostic or examination procedures if indicated that will be carefully performed but may be uncomfortable.

It is important you and your child understand, as with any health care approach, results are not guaranteed, and there is no promise to cure. As with all types of health care, there are some risks, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burn and/or scarring from electrical stim or cold therapies, broken bones, disc injuries, dislocations, strains and sprains and strokes.

With respect to stroke, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in normal, healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing and driving. Arterial dissection occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients, who experience the condition often, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1 million to 1 in 2 million cervical adjustments.

It is also important that you understand that there are treatment options available for your child's condition other than chiropractic procedures. Likely, you have tried many of these approaches already and have the right to a second opinion about your child's circumstances and health care as you see fit.

I understand that if my child is accepted as a patient by Bettendorf Chiropractic Wellness Center, I have read, or have had read to me, the above consent. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to my child and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment for my child, any fees for professional services rendered to my child will be immediately due and payable. I am authorizing them to proceed with any treatment that may be necessary for my child. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care for my child is deemed appropriate for any circumstance for which I seek chiropractic care for my child from Bettendorf Chiropractic Wellness Center.

I hereby authorize Gina M. Lehman, DC, FASA and Keeli L. Farley, DC and whomever they may designate as an assistant to examine and administer treatments as deemed necessary to my child, _____.

Printed name of person authorizing treatment: _____

Signature: _____

Date: _____ Relationship to Child: _____

You have been offered a copy of our financial policy. _____(initial)

You have been offered a copy of our HIPAA privacy policy. _____(initial)

May we confirm your appointments by email, text or phone? (circle one) YES NO

In order to provide you the best possible wellness care, please complete the form.
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