File # _____

Date: _____

Patient Health History

Chiropractic Arts & Natural Medicine Center

In order to provide you the best possible chiropractic care, please complete this form as accurately as possible. All information is CONFIDENTIAL.

PATIENT DATA & DEMOGRAPHICS

First Name _____ M.I. _____ Last _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ (cell) _____ (work) _____

Age _____ Birth Date _____ Social Security Number _____

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____ # of Children _____

Occupation _____ Employer _____ Avg. hours worked per week: _____

Email _____

Referred By _____ or How did you hear about us? _____

Medical Doctor _____ City _____

Emergency Contact _____ Phone # _____ Relationship _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name _____ Date of last adjustment _____

Preferred Language: ☐ English ☐ Other_____ ☐ Male ☐ Female Sex at Birth: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White (Caucasian) ☐ Other ☐ I Decline to Answer

Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

FINANCIAL INFORMATION

☐ I will be paying for the services myself (Cash patient) ☐ Health Insurance* ☐ Auto Insurance

☐ Worker's Compensation ☐ Other _____ ☐ If child, who is responsible for bill? _____

***PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK. A COPY WILL BE PLACED IN YOUR FILE.**

PURPOSE OF THIS VISIT

Reason for this Visit: _____

When did your symptoms start? _____

How did you injure yourself? _____

Please select all that apply:

☐ Achy	☐ Radiating	☐ Stabbing	☐ Constant (75-100% of the day)
☐ Burning	☐ Sharp	☐ Stiffness	☐ Frequent (50-75% of the day)
☐ Dull	☐ Shooting	☐ Tingling	☐ Intermittent (25-50% of the day)
☐ Numbness	☐ Soreness	☐ Other	☐ Occasional (0-25% of the day)

Intensity of your symptoms: (No Pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

The symptoms improve when I... _____

The symptoms worsen when I... _____

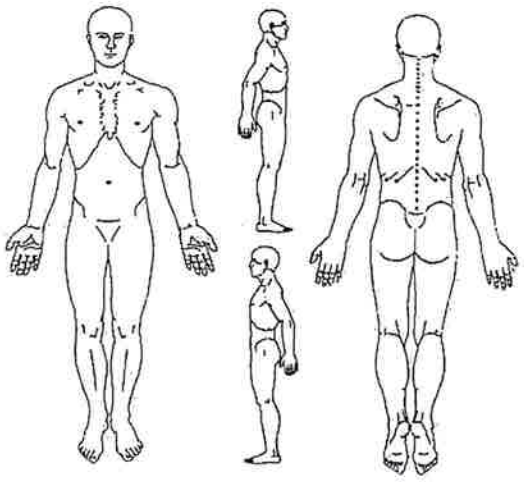
This prevents me from... _____

Home Remedies Used: ☐ Ice ☐ Heat ☐ Tylenol ☐ Ibuprofen ☐ Other _____

Who have you seen for your symptoms? ☐ No one ☐ Chiropractor ☐ Surgeon ☐ MD ☐ Physical Therapist ☐ Other

What treatments/tests were performed: ☐ X-ray ☐ MRI ☐ Other _____

Please Indicate where you have pain or other symptoms:



Comments _____

HEALTH HISTORY

Have you ever experienced this problem before? ☐ Yes ☐No Please State: _____

Have you ever had any surgery? ☐ Yes ☐No Please State: _____

Have you ever had any car accidents? ☐ Yes ☐No Please State: _____

Sports injuries, falls, broken bones? ☐ Yes ☐No Please State: _____

Smoking Status: ☐ Every Day Smoker/# of Packs per Day: _____ ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Do you consume alcohol? ☐ Yes ☐ No # of Drinks per week: _____

Do you exercise? ☐ No ☐ Yes If yes, how many days per week do you exercise? ☐ 1-2 days ☐ 3-4 days ☐ 5+days

Women only: Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Anticipated Due Date: _____

Are you currently taking any medications? ☐ Yes ☐ No (Please include prescriptions & regularly used over the counter medications.)

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency

Do you have any medication allergies? ☐ Yes ☐ No (If Yes, Please List below.)

Medication Name	Reaction	Onset Date	Additional Comments

Personal Health History: Please check all that you have or have had:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/ Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Excessive Menstruation
- ☐ Eye Pain/ Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart: Irregular Beat
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Migraine Headache
- ☐ Multiple Sclerosis
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep Problems/ Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Weight Loss
- ☐ Other (List): _____ _____

Family History: Please note any family history of the following conditions and include relationship of relative to you:

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Headache _____
- ☐ High Blood Pressure _____
- ☐ Arthritis _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Spine or back disorder _____
- ☐ Multiple Sclerosis _____
- ☐ Psychological Problems _____
- ☐ Other _____

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

_____

Patient's Signature

Chiropractic Arts Functional Health Center
1019 S Grand Ave #5
Spencer, IA 51301
712-580-5090

ACKNOWLEDGEMENT: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient Name Printed _____ Date _____

Patient Signature _____ Authorized Provider Rep. _____

Personal Representative Printed _____ Personal Rep. Signature _____

Description of personal representative's authority to act for the patient _____

Chiropractic Arts Functional Health Center
1019 S Grand Ave #5
Spencer, IA 51301
712-580-5090

Risk of remaining untreated:

Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make further rehabilitation more difficult. Delaying treatment of nutrient therapy can lead to a variety of chronic diseases such as diabetes, heart disease, cancer, stroke, death etc.

Unusual Risks:

I have had any unusual risk of my case explained to me. I have read the explanation above of chiropractic, nutrition, laser, and acupuncture treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risk and benefits of undergoing treatment and understand that no guarantees of outcomes have been made. I have also disclosed all medical information to the doctor.

By signing this document, I have freely decided to undergo the recommended treatment, and hereby give my full consent for treatment. I accept the risks and release Chiropractic Arts Functional Health Center of any liability for any injury or loss directly related to care I have received at this clinic.

Patient Name: _____ Date: _____

Patient Signature: _____

Parent or Legal Guardian's Signature (if patient is under 18): _____

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Informed Consent for Chiropractic, Nutrition, Acupuncture, and Laser

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints in a very specific way. You may feel a "click" or "pop" and you may feel movement of the joint. This is normal, but does not always occur with every adjustment.

The nature of Acupuncture treatment: The doctor may also use acupuncture as an adjunct, or in while, during your care. Acupuncture involves the insertion of tiny needles into the body through the skin. It may also involve the use of pressure or electrical stimulation separately, or in conjunction with needling. Cupping may also be used during Acupuncture sessions and you may end up with some bruising that does goes away.

The nature of Nutrition treatment: The doctor may also advocate the use of specific nutrients during your care. This involves the prescription of brand name individual or combination products. Rest assured that Dr. Elizabeth Kressin and Dr. Rex Jones uses only the highest quality products. Possible risks with all health care, complications are possible following a chiropractic, acupuncture, laser, and nutrition therapy.

The nature of Laser treatment: The doctor may recommend use of low-level laser therapy during your care. Low level laser therapy involves use of red light or violet light which is not heat producing. Laser complications are rare with low level laser therapy. The only caution is with pacemakers, defibrillators, and devices with a battery for spinal stimulations.

---Chiropractic complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. These complications are extremely rare occurrences. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

---Acupuncture complications include infection at the needling site, organ perforations, bleeding, and pneumothorax. The style of acupuncture used by Dr. Elizabeth Kressin and Dr. Rex Jones is typical more superficial lessening the possibility of complications.

---Nutritional complications include the risk of adverse nutrient-reactions and hypersensitivity. Nutrients are in general well tolerated, however as with any medication, if any adverse symptoms occur with nutrient use, discontinue immediately and consult your treating doctor.

The risk of complications dur to chiropractic treatment have been described as "rare". The risk of cerebrovascular injury or stroke, has been estimated as one in one million to one is twenty million, and can be even further reduced by screening procedures. It is safer to get adjusted than it was to get in your car and drive to our clinic! The probability of adverse reaction dur to acupuncture and nutrient therapy are also considered "rare". They would be significantly less than the chance of adverse complications due to prescription medication use or surgery. The probability of adverse reaction to laser therapy is extremely rare and review of warnings only advise asking cardiologist or neurologist of laser treatments contraindicated with pacemakers or spinal implant devices with batteries.

Chiropractic
Acupuncture
Laser Therapy
Functional Lab Analysis

1019 S Grand Ave. #5
Dr. Elizabeth Kressin
Dr. Rex Jones

CHIROPRACTIC ARTS & FUNCTIONAL HEALTH CENTER, P.C
(712) 580-5090 FAX: 580-5091

Print Full Name _____ Do you have any changes to Insurance Y/N

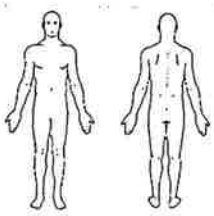
Is this visit being submitted to an accident Insurance policy (Aflac, Combined, Colonial)? Y/N
If yes, date of injury:_____ Injury: _____

Reason for visit: _____

Rate the Severity of Your Pain (if any):

	Mild			Moderate				Severe		
0	1	2	3	4	5	6	7	8	9	10

Describe the Pain or sensation: (circle) Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Stiffness Swelling Other



Pain Intensity:
- 0 No Pain
- 1 Mild Pain
- 2 Moderate Pain
- 3 Severe Pain
- 4 Worst Possible Pain

Frequency of pain:
- 0 No Pain
- 1 Occasional Pain 25% of the day
- 2 Intermittent Pain 50% of the day
- 3 Frequent Pain 75% of the day
- 4 Constant Pain 100% of the day

Sleeping:
- 0 Perfect
- 1 Mildly disturbed
- 2 Moderately disturbed
- 3 Greatly disturbed
- 4 Totally disturbed

Personal Care (washing, dressing, etc.):
- 0 No pain/no restrictions
- 1 Mild pain/no restrictions
- 2 Moderate pain/need to go slowly
- 3 Moderate pain/ need some assistance
- 4 Severe pain/ need 100% assistance

Travel (driving, flying, etc.):
- 0 No pain on long trips
- 1 Mild pain on long trips
- 2 Moderate pain on long trips
- 3 Moderate pain on short trips
- 4 Severe pain on short trips

Work:
- 0 Can do usaul plus unlimited extra work
- 1 Can do usual/no extra
- 2 Can do 50% of usual
- 3 Can do 25% of usual
- 4 Cannot work

Recreation:
- 0 Can do all activities
- 1 Can do most activities
- 2 Can do some activities
- 3 Can do a few activities
- 4 Cannot do any activities

Lifting:
- 0 No pain with heavy weight
- 1 Increased pain with heavy weight
- 2 Increased pain with moderate weight
- 3 Increased pain with light weight
- 4 Increased pain with any weight

Walking:
- 0 No pain any distance
- 1 Increased pain after one mile
- 2 Increased pain after one half mile
- 3 Increased pain after one quarter mile
- 4 Increased pain with all walking

Standing:
- 0 No pain after several hours
- 1 Increased pain after several hours
- 2 Increased pain after one hour
- 3 Increased pain after one half hour
- 4 Increased pain with any standing

Signature _____ Date _____ Total Score _____