



Linster Chiropractic

*Flexibility, Clarity & Balance
For Your Spine
Your Nervous System
Your Life!*

Your Health Profile

PLEASE PRINT CLEARLY

Today's Date: _____

Your Email (optional): _____

Full Name: _____ Birth Date: _____ Age: _____

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

Home Phone: _____ Cell: _____ Work: _____

Gender: M / F Social Security # _____ Marital Status: S/M / D/ W # of Children _____

Occupation: _____ Full Time Part Time Retired Other _____

Work Activity: Sitting Standing Computer/Phone (ergonomic /not ergonomic) Light Labor Heavy Labor

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

How did you hear about Linster Chiropractic? Whom may we thank for referring you? _____

Our Patient Health Information Policies

We want you to know how your (or your dependent's) Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow Linster Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. You, the patient or guardian give us your consent to use your name for the purpose of Welcomes, Referrals , Testimonials, Kids Photo Boards, Birthdays, and etc strictly for special acknowledgments.

I have read and understand how my (or my dependent's) Patient Health Information will be used and I agree to these policies and procedures.

Patient's (or Guardian) Signature

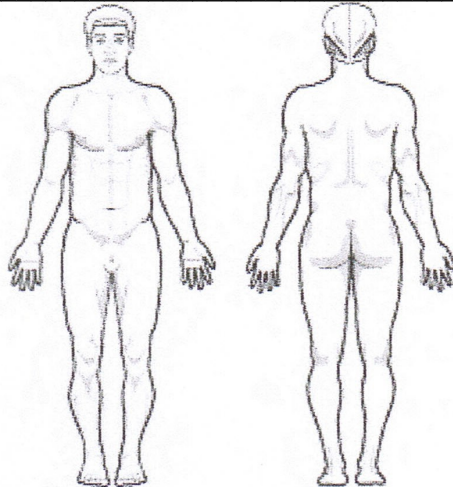
Date

Patient Name: _____

Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority and draw any pain patterns on the images below. If identifying pain, please describe pain. Finally, grade your pain for each problem listed.

- 1) _____
Sharp Dull Numbness Tingling Ache Burning Stabbing Throbbing Stiffness Cramping Swelling Other
- 2) _____
Sharp Dull Numbness Tingling Ache Burning Stabbing Throbbing Stiffness Cramping Swelling Other
- 3) _____
- 4) _____
- 5) _____



GRADE YOUR PAIN	
1 (= none) to 10 (= very severe)	
PROBLEM #	GRADE
1	1 2 3 4 5 6 7 8 9 10
2	1 2 3 4 5 6 7 8 9 10
3	1 2 3 4 5 6 7 8 9 10
4	1 2 3 4 5 6 7 8 9 10
5	1 2 3 4 5 6 7 8 9 10

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to 'patch up the symptoms' of my problem.
- I am looking to resolve my symptoms and then go on to 'fix the cause' of my problem.
- I am looking to take care of my problems and then go on to 'achieve optimal health and wellness'.

IN RELATION TO YOUR PRIMARY CONDITION:

Is this condition due to an accident? Y N Date: _____ Type: Auto Work Home Other _____

When did you first seek treatment for this problem? _____

Has another doctor(s) treated you for this condition Y N Whom? _____ Treatment: _____

Have you had any intolerance or reactions to treatments? Y N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

How has it changed recently? Same Better Suddenly Worse Gradually Worse Date: _____

How frequent is this condition? Constant Daily Intermittent Morning Only Night Only

How long does it last? All Day A Few Hours Minutes It Doesn't Stop

Is this condition interfering with your: Work Sleep Daily Routine Recreation Other _____

How long has it been since you really felt good? Days Weeks Months Years > 10 years

What makes it worse? Sitting Standing Lying Walking Getting up from chair Bending Lifting Other _____

Is there anything you can do to relieve the problem? Y N Describe: _____

If no, what have you tried that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions/symptoms related to your major symptom? Y N If yes, what? _____

Patient Name: _____ GENERAL HEALTH HISTORY Date: _____

Primary Care Physician: _____ Office Phone: _____

Date of Last Physical: _____ Spinal X Ray/MRI/CT: _____ Blood Test: _____ Bone Density: _____

PLEASE CHECK ALL OF THE SYMPTOMS THAT APPLY: (P=PAST / C=CURRENT)

<u>P / C General</u>	<u>P / C EENT</u>	<u>P / C Respiratory</u>	<u>P / C Gastrointestinal</u>
<input type="checkbox"/> Headache	<input type="checkbox"/> Failing Vision	<input type="checkbox"/> Smoke #/day _____	<input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Nausea
<input type="checkbox"/> Fever	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Unsteady Voice	<input type="checkbox"/> Constipation
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Earache	<input type="checkbox"/> Spitting Up Blood	<input type="checkbox"/> Colitis/ IBS
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Confusion	<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Head Pressure	<input type="checkbox"/> Excessive Thirst	<u>Cardiovascular</u>	<input type="checkbox"/> Stomach Pain
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Lump in Throat	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Bloody Stool
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Swallowing Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Movement Loss	<input type="checkbox"/> Difficult Swallowing	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Acid Reflux /GERD
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Pain Over Heart	<input type="checkbox"/> Polyps
<input type="checkbox"/> Arm Numbness		<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Esophageal Erosion
<input type="checkbox"/> Arm Pain	<u>Urinary</u>	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Loss of Bowel Control
<input type="checkbox"/> Arm Tingling	<input type="checkbox"/> Freq/Urgent Urination	<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Very Thirsty
<input type="checkbox"/> Chest Pressure	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Very Hungry
<input type="checkbox"/> Chills	<input type="checkbox"/> UTIs	<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Fainting	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Abdominal Hernias
<input type="checkbox"/> Leg Numbness	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Severe Bad Breath
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Leg Tingling	<input type="checkbox"/> Kidney Stone		<u>Illnesses</u>
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Prostate Disease	<u>Joint/Muscle</u>	<input type="checkbox"/> Cancer
<u>Reproductive</u>	<input type="checkbox"/> Surgeries/Lifts	<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Cramps	<u>Skin</u>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Yeast Infections	<input type="checkbox"/> Rash	<input type="checkbox"/> Joint Swelling/Pain	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Slow Healing Wound	<input type="checkbox"/> Tremors	<input type="checkbox"/> Polio
<input type="checkbox"/> Hemorrhaging	<input type="checkbox"/> Hives	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> Difficulty	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Shoulder/Arm Pain	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Getting Pregnant	<input type="checkbox"/> Prone to Infection	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Itching	<input type="checkbox"/> Elbow/Hand Pain	<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Skin Malignancies	<input type="checkbox"/> Inflexibility	<input type="checkbox"/> Melanoma
<input type="checkbox"/> Ovarian Problem		<input type="checkbox"/> Nerve Pain that travels down _____	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Uterine Problem		<input type="checkbox"/> Herniated Discs	<input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Cancer			<input type="checkbox"/> Reflex Sympathetic Dystrophy

ALLERGIES: Please check and list all allergies

Food: _____

Seasonal: _____

Environmental: _____

Medications: _____

Patient Name: _____

Date: _____

Are you pregnant? Y N Due Date: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began them.

Drug Type	Drug Name	Date Started
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-inflammatory		
<input type="checkbox"/> Arthritis Drugs		
<input type="checkbox"/> Behavioral Modification		
<input type="checkbox"/> Blood Pressure Lowering		
<input type="checkbox"/> Cholesterol Lowering		
<input type="checkbox"/> Hormone Replacement		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

SUPPLEMENTS: List vitamins/supplements/herbs/homeopathics _____
Who recommended them? _____

HABITS: Heavy Moderate Light None Exercise Type Time

Alcohol Exercise 5-7x/wk 3-5x/wk 1-3x/wk _____

Coffee Sleep 8+ hrs 7-8 hrs 6-7hrs 5-6 hrs <5hrs _____

Drugs Meals 5+ 4 3 2 1 _____

Soda Water 64+oz 32-64oz 16-32oz <8oz _____

Stress Type of Stress: Physical / Emotional / Chemical _____

INJURIES/SURGERIES you have had: Description Date

Car Accidents 1. _____
2. _____
3. _____

Falls (down stairs, on ice, etc) _____

Head Injuries/Concussions _____

Broken Bones _____

Dislocations/Sprains _____

Surgeries _____

FAMILY HISTORY: Identify any conditions that you or any of your family members have now or have had in the past: (G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

____ Alcoholism/Drug Abuse ____ Eczema ____ Miscarriage(s) ____ Tumor(s) ____ Stroke
 ____ Deep Vein Thrombosis ____ Cancer ____ Pneumonia ____ Cold Sores ____ Mumps
 ____ Detached Retina ____ Goiter ____ Diabetes ____ Epilepsy ____ Polio
 ____ Diverticulitis/IBS ____ Anemia ____ Emphysema ____ Pleurisy ____ Heart Disease
 ____ Rheumatic Fever ____ Ulcers ____ Hepatitis ____ HIV/AIDS ____ Vaccine Reaction
 ____ Seizures/Fainting ____ Gout ____ Other _____

