

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHIROPRACTIC GOALS

- Pain Relief Only:** I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.
- Maintenance and Prevention:** I seek help to keep problems from recurring. I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better, and it maximizes my potential.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you under regular Chiropractic Care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

COMMENTS: _____

ADULT (18 TO PRESENT)

	Yes	No		Yes	No
Do or did you ever smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do or did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do or did you ever drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do or did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in ANY accidents?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received a professional massage?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how often? _____ Date of last massage _____		

On a scale of Poor, Fair, Good, Excellent, describe your:
 Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services only, please check (✓) here:

- Wish to have Chiropractic Wellness Service**

Others need to briefly describe the chief area of complaint, and the effect it has had on your life.

If you are experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant

Since the problem started, it is: About the same Getting Better Getting Worse

What makes it better: _____

What makes it worse: _____

It interferes with: Work Sleep Walking Sitting Hobbies Leisure

Addressing The Issues That Brought You To The Office (cont.)

Have you seen other professionals for this problem? (please list)

- Chiropractor
-
- Medical Doctor
-
- Massage Therapist
-
- Other
-

Severity of Pain
List region of pain and circle severity number. (0=least, 10=greatest)

Mark Pain Region
Burning - Stabbing - Sharp - Constant

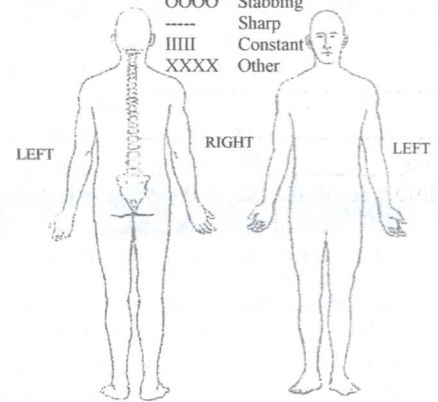
Ex. Neck SHARP

0 1 2 3 4 5 6 7 8 9 10

Regions

Neck	0 1 2 3 4 5 6 7 8 9 10
Mid-Back	0 1 2 3 4 5 6 7 8 9 10
Low-Back	0 1 2 3 4 5 6 7 8 9 10
Hips	0 1 2 3 4 5 6 7 8 9 10
Arms	0 1 2 3 4 5 6 7 8 9 10
Legs	0 1 2 3 4 5 6 7 8 9 10

Mark Pain Area
++++ Burning
OOOO Stabbing
---- Sharp
IIIIII Constant
XXXX Other



Are you currently: Seeing a health practitioner? Seeking psychotherapy? Attending regular support group meetings?

If yes, please explain: _____

What are the main sources of stress in your life? Please include any stress-reducing activities you do and the frequency.

Where in your body do you feel the effects of stress? _____

Please mark all symptoms you have currently or ever have had, even if they do not seem related to your current problem, **C=Current P=Past**

Breathing difficulties	High or Low Blood pressure	Pins and Needles in Legs/Tingling	Pins and Needles in arms/Tingling	Diarrhea or Constipation
Allergies	Fainting	Loss of smell	Back Pain	Loss of Balance
Rashes	Dizziness	Buzzing in ears	Ringling in ears	Nervousness
Sinus problems	Neck stiff	Numbness in toes	Loss of taste	Stomach upset
Eating disorders	Fatigue	Depression	Irritability	Tension
Varicose veins	Neck Pain	Fever	Cold hands	Cold feet
Sensitivity to light	Sleeping Problems	IBS	Numbness in fingers	Problems urinating
Athlete's foot	Cold Sweats	Blood clots	Hot flashes	Heartburn
Lymph edema	Mood Swings	Menstrual pain	Ulcers	Menstrual irregularity
Endometriosis	Lupus	Tendonitis	Bursitis	Bone or joint disease
Diabetes	Spasms/cramps	Heart conditions	Sprain/strain	Low back, hip, leg pain
Broken/fractured bones	Infectious disease —Disease name: _____		Neck, shoulder, arm pain	Headaches/head injuries
Cancer/tumors	Warts	Gas/bloating	Diverticulitis	Drug/alcohol addictions
Arthritis	Chronic pain	Pregnant	Jaw pain	

List any medications you are taking: _____

Initial **Cancellation Policy:** Any cancellations need 24-hours notice. If you do not give adequate notice, you will be charged for the scheduled services (Some exceptions may apply). If you are late for a massage, you can still receive it, but a shortened version, i.e. Being 15 minutes late for a 1 hour massage will result in receiving a 45 minute massage.

Initial **Communication Policy:** It is my choice to receive Chiropractic and Massage services. I agree to COMMUNICATE with my practitioner any time I feel like my well being is being compromised.

The statements on this form are accurate to the best of my recollection and I agree to update this office of any changes. I also agree to allow this office to examine me for further evaluation.

Signature: _____ Date: _____

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Mailing and Residence City State Zip code

Home Telephone () Work Phone () Cell Phone ()

Email Address _____ I would like to receive newsletters via e-mail yes no

Male Female Social Security # _____ Birth date: _____

Occupation/Employer _____

Single Married Divorced Widowed Spouse: _____

Emergency Contact: _____ Phone: _____

Reason for Consulting Our Office: _____

Who may we thank for referring you to our office? _____

CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment below.

Patient Signature or Authorized Person Acting on Patient's Behalf Date

B. I authorize payment of any medical benefits from _____ to be paid directly to Dr. Gofourth/Veneta Chiropractic Clinic for any services rendered to me.

Patient Signature or Authorized Person Acting on Patient's Behalf Date

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorized you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies process, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collections and/or recovery in this state/province of Oregon.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed Dr. Gofourth/Veneta Chiropractic Clinic, are paid in full.

Patient Signature or Authorized Person Acting on Patient's Behalf Date

RECORDS RELEASE

To _____, I hereby authorize you to release to Dr. Gofourth/Veneta Chiropractic Clinic any information including the diagnosis and records of any examination or treatment rendered to me during the period between _____ and _____.

Patient Signature or Authorized Person Acting on Patient's Behalf Date

Staff/Witness Signature Date