

# PATIENT HISTORY

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Email Address \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Have you ever been to another doctor for this problem? Y N Who? \_\_\_\_\_  
Who referred you to this office? \_\_\_\_\_

## WHAT BRINGS YOU TO OUR OFFICE?

### FIRST COMPLAINT: \_\_\_\_\_

- Date when symptom first appeared \_\_\_\_\_
- Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb
- Does the Pain Radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate
- Do you experience Numbness or Tingling? \_\_\_\_\_ Y \_\_\_\_\_ N
- How often do you experience these symptoms?  
\_\_\_\_\_ 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain \_\_\_\_\_ Unbearable Pain

### OTHER COMPLAINT: \_\_\_\_\_

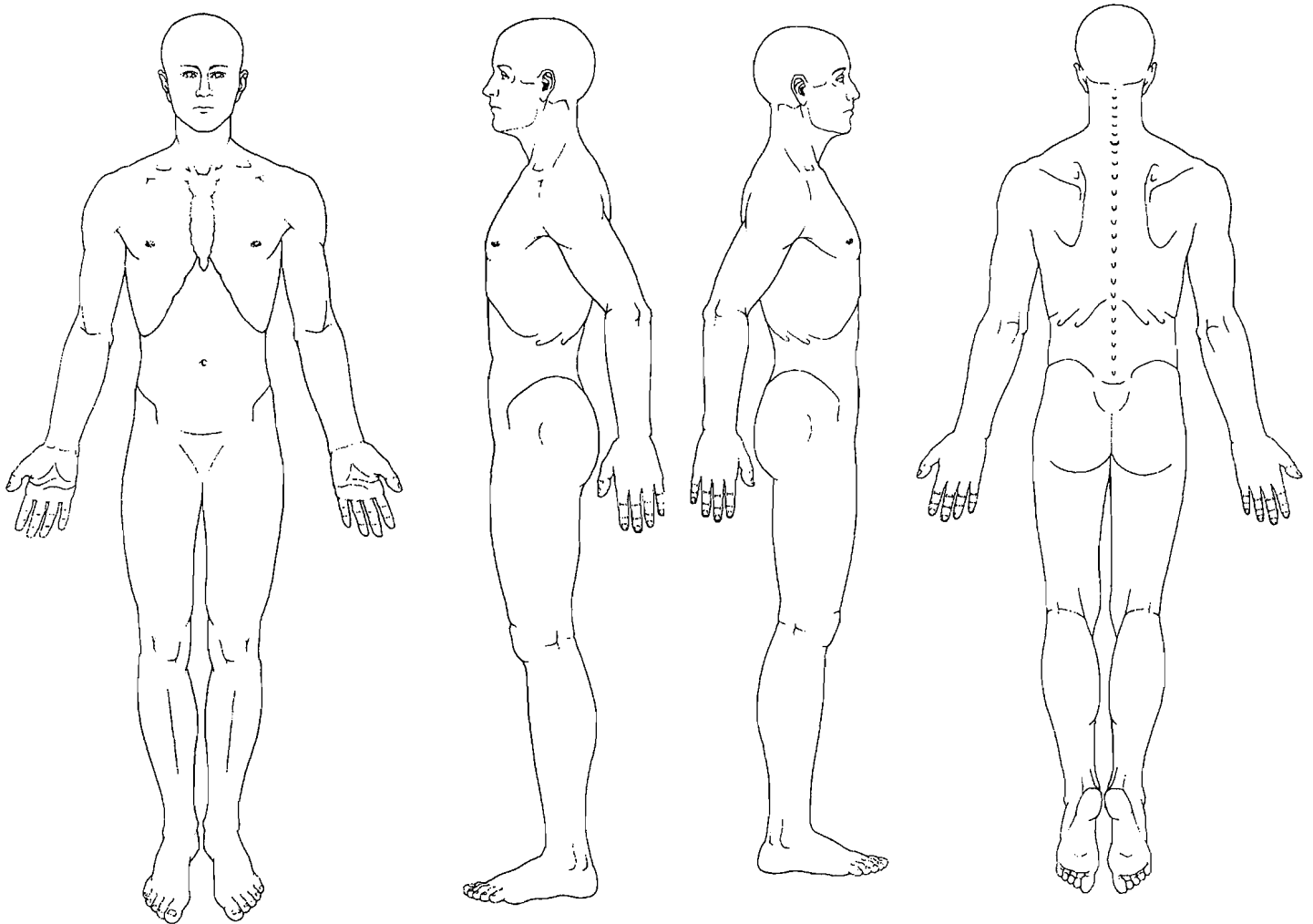
- Date when symptom first appeared \_\_\_\_\_
- Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
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- Does the Pain Radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate
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- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain \_\_\_\_\_ Unbearable Pain

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# PATIENT HISTORY

## PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.  
Please use the following symbols on the pain diagram to accurately  
describe your condition.**

- |            |                                      |
|------------|--------------------------------------|
| <b>PPP</b> | <b>Where you experience Pain</b>     |
| <b>NNN</b> | <b>Where you experience Numbness</b> |
| <b>TTT</b> | <b>Where you experience Tingling</b> |
| <b>BBB</b> | <b>Where you experience Burning</b>  |
| <b>CCC</b> | <b>Where you experience Cramping</b> |

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# REVIEW OF SYSTEMS

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## **PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:**

### **GENERAL INFORMATION:**

ANY RECENT WEIGHT GAIN/LOSS \_\_\_\_\_  
WEAKNESS \_\_\_\_\_  
FATIGUE \_\_\_\_\_  
FEVER \_\_\_\_\_  
FAINTING SPELLS \_\_\_\_\_  
NAUSEA \_\_\_\_\_  
VOMITING \_\_\_\_\_  
BALANCE PROBLEMS \_\_\_\_\_  
JAW PAIN (TMJ) \_\_\_\_\_  
NECK PAIN \_\_\_\_\_  
NECK STIFFNESS \_\_\_\_\_  
SHOULDER PAIN \_\_\_\_\_  
ARM PAIN \_\_\_\_\_  
WRIST/HAND PAIN \_\_\_\_\_  
NUMBNESS ARMS OR HAND \_\_\_\_\_  
UPPER BACK PAIN \_\_\_\_\_  
LOWER BACK PAIN \_\_\_\_\_  
HIP PAIN \_\_\_\_\_  
LEG PAIN \_\_\_\_\_  
ANKLE/FOOT PAIN \_\_\_\_\_  
NUMBNESS LEGS OR FEET \_\_\_\_\_  
JOINT SWELLING \_\_\_\_\_  
TENSION \_\_\_\_\_  
NERVOUSNESS \_\_\_\_\_  
ANXIETY \_\_\_\_\_  
IRRITABILITY \_\_\_\_\_  
SLEEPING PROBLEMS/INSOMINA \_\_\_\_\_  
DEPRESSION \_\_\_\_\_  
LIVER PROBLEMS \_\_\_\_\_  
CANCER (IF YES INDICATE WHEN AND TYPE) \_\_\_\_\_

\_\_\_\_\_

METAL IMPLANTS (IF YES INDICATE WHEN AND WHERE) \_\_\_\_\_

\_\_\_\_\_

### **HEAD:**

HEADACHES \_\_\_\_\_  
LOSS OF CONSCIOUSNESS \_\_\_\_\_  
DIZZINESS \_\_\_\_\_  
MEMORY PROBLEMS \_\_\_\_\_  
SEIZURES/CONVULSIONS \_\_\_\_\_

### **EYES:**

WEAR EYE GLASSES/CONTACT LENSES \_\_\_\_\_  
DOUBLE VISION \_\_\_\_\_  
BLURRED VISION \_\_\_\_\_  
LOSS OF VISION \_\_\_\_\_  
EYES SENSITIVE TO LIGHT \_\_\_\_\_

### **EARS:**

LOSS OF HEARING \_\_\_\_\_  
RINGING/BUZZING IN EARS (TINNITIS) \_\_\_\_\_  
EAR INFECTIONS \_\_\_\_\_  
VERTIGO (DIZZINESS) \_\_\_\_\_  
ANY DISCHARGE FROM EARS \_\_\_\_\_

### **NOSE:**

SINUS PROBLEMS \_\_\_\_\_  
EPITAXIS (NOSEBLEEDS) \_\_\_\_\_  
LOSS OF SMELL \_\_\_\_\_  
ANY DISCHARGE FROM NOSE \_\_\_\_\_

### **MOUTH/THROAT:**

TOOTH PAIN \_\_\_\_\_  
ANY LESIONS/SORES IN MOUTH, LIPS OR GUMS \_\_\_\_\_  
FREQUENT SORE THROATS \_\_\_\_\_  
DIFFICULTY SWALLOWING \_\_\_\_\_  
THYROID PROBLEMS \_\_\_\_\_

### **RESPIRATORY (LUNG PROBLEMS):**

DIFFICULTY BREATHING \_\_\_\_\_  
CHRONIC COUGH \_\_\_\_\_  
ASTHMA \_\_\_\_\_  
BRONCHITIS \_\_\_\_\_  
EMPHYSEMA \_\_\_\_\_  
EVER HAVE TUBERCULOSIS OR PNEUMONIA \_\_\_\_\_  
DATE OF LAST CHEST RADIOGRAPH \_\_\_\_\_

### **CARDIOVASCULAR (HEART PROBLEMS):**

CHEST PAIN \_\_\_\_\_  
DIFFICULTY BREATHING (SHORTNESS OF BREATH) \_\_\_\_\_  
PALPITATIONS \_\_\_\_\_  
NIGHT SWEATS \_\_\_\_\_  
COLD EXTREMITIES \_\_\_\_\_  
HIGH BLOOD PRESSURE \_\_\_\_\_  
LOW BLOOD PRESSURE \_\_\_\_\_  
HEART MURMUR \_\_\_\_\_  
EVER HAVE AN ECG/EKG \_\_\_\_\_

### **GI (GASTROINTESTINAL):**

UPSET STOMACH \_\_\_\_\_  
LOSS OF APPETITE \_\_\_\_\_  
INDIGESTION \_\_\_\_\_  
CONSTIPATION \_\_\_\_\_  
DIARRHEA \_\_\_\_\_  
BLOODY STOOL \_\_\_\_\_  
ABDOMINAL PAIN \_\_\_\_\_  
EXCESSIVE GAS \_\_\_\_\_  
LOSS OF BOWEL CONTROL \_\_\_\_\_

CONTINUED ON NEXT PAGE →

**ROS FORM CONTINUED:**

**PATIENT NAME:** \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:**

**GU (GENITALURINARY):**

**FEMALES:**

HISTORY OF PELVIC INFLAMMATORY DISEASE \_\_\_\_\_  
 URINARY TRACT INFECTIONS \_\_\_\_\_  
 BREAST CANCER &/OR BENIGN TUMORS \_\_\_\_\_  
 BLOOD IN URINE \_\_\_\_\_  
 PAINFUL URINATION \_\_\_\_\_  
 VAGINAL DISCHARGE \_\_\_\_\_  
 PMS \_\_\_\_\_  
 LOSS OF BLADDER CONTROL \_\_\_\_\_  
 CURRENTLY PREGNANT \_\_\_\_\_  
 USE BIRTH CONTROL PILLS \_\_\_\_\_  
 DATE OF LAST MENSTRUAL PERIOD (DLMP) \_\_\_\_\_  
 IF INDICATED AGE OF MENOPAUSE \_\_\_\_\_  
 LAST PELVIC EXAM (DATE & RESULTS) \_\_\_\_\_  
 \_\_\_\_\_  
 LAST PAP SMEAR (DATE & RESULTS) \_\_\_\_\_  
 \_\_\_\_\_  
 LAST BREAST EXAM (DATE & RESULTS) \_\_\_\_\_  
 \_\_\_\_\_  
 ANY SEXUAL TRANSMITTED DISEASE (STD'S) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MALES:**

PROSTATE PROBLEMS \_\_\_\_\_  
 HERNIAS \_\_\_\_\_  
 PENILE DISCHARGE \_\_\_\_\_  
 BLOOD IN URINE \_\_\_\_\_  
 PAINFUL URINATION \_\_\_\_\_  
 FREQUENT URINATION \_\_\_\_\_  
 TESTICULAR PAIN \_\_\_\_\_  
 LOSS OF BLADDER CONTROL \_\_\_\_\_  
 LAST PROSTATE EXAM (DATE & RESULTS) \_\_\_\_\_  
 \_\_\_\_\_  
 LAST PSA (DATE & RESULTS) \_\_\_\_\_  
 \_\_\_\_\_  
 ANY SEXUAL TRANSMITTED DISEASES (STD'S) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ENDOCRINE:**

COLD OR HEAT INTOLERANCE \_\_\_\_\_  
 EXCESSIVE SWEATING \_\_\_\_\_  
 EXCESSIVE THRIST OR HUNGER \_\_\_\_\_  
 DIABETES \_\_\_\_\_ (IF YES, INDICATE IF INSULIN DEPENDENT) \_\_\_\_\_  
 THYROID PROBLEMS \_\_\_\_\_  
 KIDNEY PROBLEMS \_\_\_\_\_

**SOCIAL HISTORY:**

USE TOBACCO (SMOKE)-IF YES INDICATE HOW MUCH AND HOW LONG BEEN SMOKING \_\_\_\_\_

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

USE ALCOHOL (DRINK)-IF YES INDICATE HOW OFTEN AND HOW MUCH \_\_\_\_\_

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

USE RECREATIONAL DRUGS-IF YES INDICATE WHAT AND HOW OFTEN \_\_\_\_\_

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

SEXUALLY ACTIVE-IF YES INDICATE WHAT FORM OF PROTECTION \_\_\_\_\_

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

**PATIENT SIGNATURE:**

X \_\_\_\_\_

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

## FAMILY HISTORY

Please review the below listed diseases and conditions and indicate those that are current and past health problems of family members. Leave those spaces blank that do not apply. Check if the family lives locally or is deceased, as some hereditary conditions are affected by similar climate.

	Age:	Deceased:	Lives Locally:
Mother			
Father			
Spouse			
Siblings:			

F = Father, M = Mother, B = Brother, S = Sister, SP = Spouse, C = Children

Arthritis		Headaches		Pinched Nerve	
Asthma-Hay Fever		Heart Trouble		Scoliosis	
Back Trouble		High Blood Pressure		Sinus Trouble	
Bursitis		Insomnia		Stomach Trouble	
Cancer		Kidney Trouble		Other:	
Constipation		Liver Trouble			
Diabetes		Migraine			
Disc Problem		Nervousness			
Emphysema		Neuritis			
Epilepsy		Neuralgia			

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing the consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# HAMMES CHIROPRACTIC, P.C.

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

- ◆ **The nature of the chiropractic adjustment.** The doctor will use his hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.
- ◆ **The material risks inherent in chiropractic adjustment.** As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
- ◆ **The probability of those risks occurring.** Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."
- ◆ **Other treatment options for your condition include:**
  - ◆ *Over-the-counter analgesics* - The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
  - ◆ Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
  - ◆ *Hospitalization* - In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
  - ◆ *Surgery* - In conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.
- ◆ **The risks and dangers attendant to 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 probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual Risks: I have had the following unusual risks of my case explained to me.**

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have fully evaluated the risks and benefits involved in undergoing treatment. I have freely decided to undergo treatment and hereby give my full consent to treatment.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian (if a minor)

WITNESS:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature