

Health History Information

Patient # _____

Welcome to our office- we are glad you chose chiropractic to take care of your health needs.

Today's Date: _____ Cell Phone: _____

Name (print): _____ Home Phone: _____

Address: _____ # _____ City: _____ Zip: _____

Birth Date: _____ Age _____ SS#: _____

Email Address: _____

Employer: _____ Work Phone: _____

Marital Status: Single Married Spouse name: _____ Divorced

Children's Names and Ages: _____

Emergency contact: _____ Relation: _____ Phone: _____

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

Have you ever been to a chiropractor before? No Yes- Dr. _____

Were you pleased with his care? Yes No- Why? _____

What type of treatments did he do for you: _____

Tell Us About Your Condition

What is your main health concern you have today? _____

When did the onset of your condition begin? _____

Is your condition: Improving Getting worse Staying the same

Do you feel: Pain Stiffness Swelling Numbness/Tingling _____

Describe what the pain feels like: Sharp Dull Soreness Throbbing

How often does the pain occur: Constant Comes and Goes _____

On a scale of 1-10 (with 0=no pain), rate the severity of your pain _____

Does your condition interfere with your: Work Sleep Exercise Daily Activities

What have you done to make it feel better? _____

What do **you** think is the cause of this condition? _____

What other health concerns are you experiencing? _____

Does anyone in your family have similar problems like the ones you have? _____

Are your present complaints the result of a previous accident? Yes No Don't Know

If yes, please describe when the accident(s) occurred and what injuries you had: _____

What other doctors have you seen for your present condition?

Dr. Name: _____ Date: _____

Did they do any special tests? X-Rays MRI CT Scan Blood test

Medication(s) Prescribed: _____

Referred you to see another Dr: _____ Other: _____

Please list all **medications** you are presently taking, what they are for and how often you take them:

1. _____

2. _____

3. _____

Please list all **vitamins/supplements** you are presently taking, and how often you take them:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Have you had any other health issues that required medical care? Yes No

Describe: _____

Have you had any serious illnesses that required hospitalization? Yes No

Describe: _____

Have you had any surgeries? No Yes _____

Have you ever broken any bones in your body? No Yes _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Doctors of chiropractic named below and/or other licensed Doctors of Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as backup for the Doctors of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to fractures, disc injuries, dislocations and muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck, leading to, or contributing to serious complications including stroke. ***However, these are extremely rare.*** I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise their judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read the above explanation of the Chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any other future conditions for which I seek treatment.

Chiropractors at Rettig Chiropractic: Dr. Robert Rettig and Dr. Gary Martin

Do not sign until you have read and understand the above.

Name of Patient (Print)

Signature

Date

Patient's Representative (Print)

Signature

Date