



CLIENT CONFIDENTIAL HISTORY AND CONSENT FORM

Please complete this form to the best of your knowledge for the answers you provide gives us a clear understanding about how we can assist your needs better. (Please Print)

Today's date:		Initial Visit Date:	
CLIENT DETAILS (CHIROPRACTIC & ART)			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /
			Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Best Contact Number- Home:	Work : Mobile:
P.O. box:	City:	State:	ZIP Code:
Occupation:		May we Contact your Physician regarding your care? <input type="checkbox"/> Yes Or <input type="checkbox"/> No	Best Contact Email:
Please Specify your Family Physician Details (if any):		Name:	Contact no.: Others:
How did you hear about us (tick one below):			
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other(Please Specify)
Other family members seen here:			
Are you pregnant? (tick one below): <input type="checkbox"/> Yes OR <input type="checkbox"/> No		If Yes, Are you in : <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third Trimester.	
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: Work phone no.:
			() ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jurmaine Health & ART or insurance company to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	
CLIENT HISTORY (CHIROPRACTIC & ART)			
(Please give your answers briefly.)			
What is Your Major Complaint?: (please describe in brief)			
What are your other concerns?			
Have you had this condition in the past?			
When did the condition begin?			



How would you describe the condition?	
Onset (check all that apply)	<input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Daily <input type="checkbox"/> Nightly <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Recurring <input type="checkbox"/> Wave Pattern <input type="checkbox"/> Wakes you up at night <input type="checkbox"/> Resting Time of the Day <input type="checkbox"/> Others
Pain Characters:	<input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Ache <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Referring <input type="checkbox"/> Radiation <input type="checkbox"/> Throbbing <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Searing
During Particular Movement?	
During Particular Exercise (if so, what type of exercises? (weighted or non weighted)	
What do you think caused this condition?	
Pain Scale (0 being no pain 10 being the worst pain or discomfort)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is there anything that you are doing to help relieve the condition?	
Is this condition Improving Unchanged Getting Worse	
Is this condition interfering with your Work Sleep Activities Other	
Please List other Doctors or Therapists who have treated this condition and type of treatments	
Have you had any other Test Procedures done?	<input type="checkbox"/> X-Ray <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Ultrasound <input type="checkbox"/> Imaging <input type="checkbox"/> Surgery (Please Explain More)
Are you Exercising or What current Activities are you actively involved in?	
Are you taking any Medications or Nutritional Supplements?	



FAMILY HISTORY (ONLY NECESSARY FOR CHIROPRACTIC FORM)	
Who in the Family might have?	<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Psychological <input type="checkbox"/> Other
Do you consume Alcohol?	<input type="checkbox"/> Yes 1). _____ Times per day/week/month/year 2). _____ number of drinks <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes 1). _____ Times per day/week/month/year 2). _____ sticks/packs <input type="checkbox"/> No
Do you do physical Work?	<input type="checkbox"/> Yes 1). <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light 2). _____ Hours per day <input type="checkbox"/> No
<p>Check all symptoms that may apply to you present now and in the past (Chiropractic and ART)</p> <p>Neuro-musculoskeletal</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Tension <input type="checkbox"/> Neck Pain <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Spasms (where) <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Rib Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Scoliosis <input type="checkbox"/> Hip Pain <input type="checkbox"/> Sacrum Pain <input type="checkbox"/> Knee Pain <input type="checkbox"/> Ankle Pain <input type="checkbox"/> Foot Pain <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Elbow Pain <input type="checkbox"/> Wrist/Hand Pain <input type="checkbox"/> Sprain/strain <input type="checkbox"/> Tears <input type="checkbox"/> Bursitis <input type="checkbox"/> Fractures <input type="checkbox"/> Bone Structure Irregularities <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizures <input type="checkbox"/> Others:	
Physician Notes:	
<p>Eyes, Ears, Nose and Throat</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Buzzing in Ears <input type="checkbox"/> Sinusitis <input type="checkbox"/> Swallowing Difficulty <input type="checkbox"/> Sleep Apnoea <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Loss of Sight/ Smell/ Taste <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Other:	
Physician Notes:	
<p>Heart and Lung</p> <input type="checkbox"/> Chest Infections /congestions <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Cold Limbs <input type="checkbox"/> Hot Limbs <input type="checkbox"/> Hypertension/ Hypotension <input type="checkbox"/> Amnemia <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Other	



Genitourinary Tract

- Back Pain during Menstruation
- Contipation
- Diahorrea
- Pain on Excretion/Urination
- Abdominal Pain
- Stones of any kind _____
- Digestion Difficulties
- Infections _____

Metabolic, Allergies and Others

- Thyroid Conditions
- Seasonal Allegies
- Hormonal Conditions
- Depression
- Anxiety
- Panic Attacks
- Bleeding Gums
- Skin Conditions
- Nausea
- Nervousness
- Irritability
- Fatigue
- Loss of Balance
- Fainting
- Head Seems Heavy
- Loss of Memory
- Others:

Physican's notes: