Wise Chiropractic, Inc

Eat Wise • Move Wise • Think Wise

6332 S. Rainbow Blvd #120 Las Vegas, NV 89118 (702)248-6292

PERSONAL HISTORY

Name: _____ Today's Date _____

Address: _____ Business Employer: _____

City: _____ Type of Work: _____

State: _____ Zip/Postal Code: _____ Work Phone: _____

Home Phone Number: _____ Cell:_____

Date of Birth: _____ Age: __ Sex: □ M □ F Circle One: Single Married Widowed Divorced Separated

Email Address:_____ Name Of Spouse (If applicable): _____

Name of Individual you authorize us to share your health information/appointment scheduling/financial information: _____

Name and Phone Number of Emergency Contact:

Referred To This Office By: _____ _____

Name of Primary Care Physician (PCP):_____

PCP Address: _____

CURRENT HEALTH CONDITION

Reason for Visit: _____

When Did This Condition Begin?_____ Has the Condition Occurred Before? □ Yes □ No

Is this condition getting worse? □ Yes □ No Rate the severity of the pain 1 (least pain) to 10 (severe pain) _____

Type of Pain: □ Sharp □ Dull □ Throbbing □ Numb □ Stiff □ Burning □ Aching □ Shooting □ Tingling □ Cramping _____

How often do you have this condition: _____ Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Lifting □ Walking □ Lying Down

Other Doctors Seen For This Condition: □ Yes □ No If Yes Who? _____

Type of Treatment: _____ Results: _____

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report Of Your Accident To Your Employer/Insurance Company: □ Yes □ No

Drugs You Take Now: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine □ Insulin □ Other

_____

Vitamins/Herbs/Minerals You are taking: _____

_____

Do You Suffer From Any Other Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones

□ Other (please list details)_____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____
Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit: _____
Date of Last: Spinal X-ray _____ MRI _____ (region:_____) Physical Exam _____

Below is a list of current or past diseases. These questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Rubella
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes (type: _____)
- ☐ Cancer (type: _____)
- ☐ Heart Disease (type: _____)
- ☐ Thyroid (type: _____)
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐
- ☐ Eczema

Have you tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 0-12 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Reflux
- ☐ Black/Bloody Stool
- ☐ Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM

- ☐ Weakness in arms/legs/body
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Cold or discolored extremities
- ☐ Fainting
- ☐ Convulsions or Seizures
- ☐ Tingling Extremities

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies (List: _____)
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems or congenital defect
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches or Infection
- ☐ Hearing Difficulty
- ☐ Stuffed Nose or Sinus Infection
- ☐ Ringing in the ears

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

FEMALES ONLY

When was your last period?

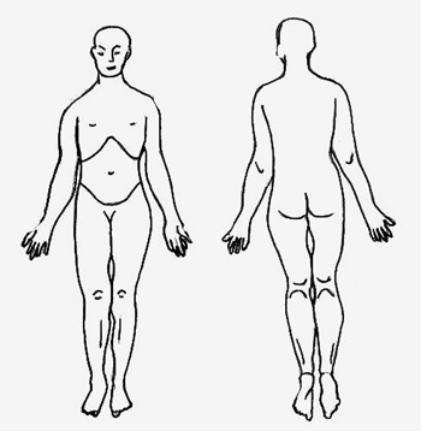
_____

Are you Pregnant?
☐ Yes ☐ No

MENTAL/EMOTIONAL

- ☐ Anxiety
- ☐ Psychotic episodes
- ☐ Attempted suicide in lifetime
- ☐ Anger/aggression
- ☐ Attention Deficit
- ☐ Depression

Please outline on the diagram the area of your discomfort



PAST HEALTH HISTORY (cont)

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

FAMILY HISTORY

List family members with the following illnesses:

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Neurological Disorder _____
- ☐ Other _____

Height_____

Weight_____

EXERCISE

- ☐ **None**
- ☐ **Mild 1-2x/wk**
  Moderate 3x/wk
- ☐ **Daily**
- ☐ **Heavy (daily and intense)**

HABITS

- ☐ **Smoking (Pack/day)_____**
- ☐ **Alcohol (Drinks/wk) _____**
- ☐ **Coffee/Caffeine (Cups/day) ___**
- ☐ **Water Ounces/day _____**

- ☐ **High Stress Level**
  Reason _____
- ☐ **Things you do to handle stress**

  _____

  _____

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) □ Yes □ No
  2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
  3. Diabetes □ Yes □ No
  4. Heart or blood vessel diseases □ Yes □ No
  5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
  7. Have any of your relatives suffered a stroke? □ Yes □ No
  8. Were you ever a smoker? If yes, from _____ to _____ □ Yes □ No
  9. Do you take any medications on a regular basis? □ Yes □ No
     - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)

       _____
  10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
     - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision □ Yes □ No
  2. Double Vision □ Yes □ No
  3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
  4. Complete loss of vision in one or both eyes? □ Yes □ No
  5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
  6. Hearing loss in one or both ears? □ Yes □ No
  7. Slurred speech or other speech problems? □ Yes □ No
  8. Difficulty swallowing? □ Yes □ No
  9. Dizziness? □ Yes □ No
  10. Temporary lack of understanding? □ Yes □ No
  11. Loss on consciousness, even momentary blackouts? □ Yes □ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
  13. Any other abnormal sensations in any part of your body? □ Yes □ No
  14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
  15. Sudden collapse without loss of consciousness? □ Yes □ No

Is your current health affecting any of the activities below? (Please circle)

Work: Yes No	**Recreation:** Yes No	**Sleep** Yes No
Social life: Yes No	**Walking:** Yes No	**Sitting:** Yes No
Exercise: Yes No	**Eating:** Yes No	**Family:** Yes No
School: Yes No	**Marriage:** Yes No	**Finances:** Yes No

If your current health condition was allowed to continue for the next 5 years, how do you think it would affect you? _____

PLEASE CHECK YOUR CURRENT HEALTH GOALS

- ☐ I am only concerned with my immediate problem and want a temporary quick fix.
- ☐ I am concerned with my immediate problem and preventing its return.
- ☐ I want to achieve optimum health and well-being on every level!
- ☐ I am interested in wellness care for myself and/or my family.

Terms of Acceptance

Wise Chiropractic is a Family Wellness Center specializing in the detection, correction and prevention of vertebral subluxations (spine and nerve system problems). We are also advanced providers for Nambudripad's Allergy Elimination Techniques, also known as NAET.

In Chiropractic, we do not treat or diagnose medical conditions nor dispense drugs. Today you will have a consultation and examination to evaluate the health of your spine and nerve system. The information will be analyzed and the doctor will discuss the results of your exam. If we accept your case, you will receive recommendations outlining the steps needed to improve your health. Our methods include spinal adjustments, nutrition, physiotherapy, rehabilitative exercises, orthotics, weight loss and stress reduction. Our goal is to teach you how to Eat Wise – Move Wise – Think Wise.

NAET is a non-invasive, drug free, natural solution to alleviate allergies of all types and intensities using a blend of selective energy balancing, testing and treatment procedures from acupuncture/acupressure, allopathy, chiropractic, nutritional, and kinesiological disciplines of medicine.

If accepted as a patient, I give consent to any and all treatment rendered to Myself or my Children, including x-rays if needed. I have been given my HIPPA rights. They are posted on the wall for review. I have been informed of the possible risks involved with chiropractic care.

By signing below, I understand and agree to these terms

Signature _____ Date _____/_____/_____

Signature of Parent (for minor): _____ Date _____ /_____/_____

Name of Parent _____