Wise Chiropractic, Inc

Eat Wise • Move Wise • Think Wise

5875 S. Rainbow Blvd #100 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?

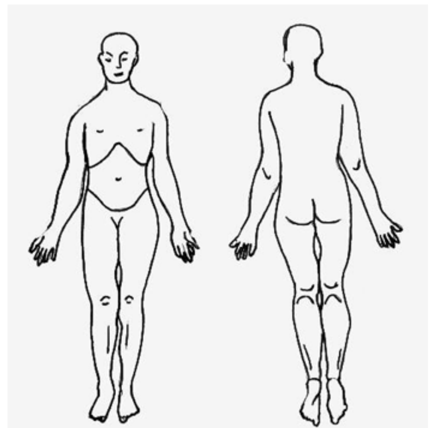
____

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 ____