

Welcome To Lotriet Family Chiropractic

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age ____ Today's Date ____/____/____
Address _____ City _____ State _____ Zip _____
Home # (____) _____ Work # (____) _____ Ext _____ Soc. Sec # ____-____-____
____ Male ____ Female Cell # (____) _____ E-mail Address _____
Occupation _____ Work Duties _____ **WOMEN ONLY: Are you pregnant? No ____ Yes ____**
Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

Your Health Profile

***FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTH OR LONGER) (Please 'Circle' if necessary to be more specific)

<input type="checkbox"/> Numbness/Tingling/Pain in (Arms / Hands / Fingers) R / L Both	<input type="checkbox"/> Hip Pain R / L	<input type="checkbox"/> Neck Stiffness / Pain	<input type="checkbox"/> Back Stiffness / Pain
<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Colds / Flu	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Convulsions / Epilepsy	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Swollen Painful Joints	<input type="checkbox"/> Tremors	<input type="checkbox"/> Blurred Vision R / L	<input type="checkbox"/> Double Vision R / L
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Pain w/ Cough / Sneeze	<input type="checkbox"/> Stroke	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Buzzing / Ringing in Ears	<input type="checkbox"/> Sinus Problems / Allergies	<input type="checkbox"/> Nervousness / Anxiety
<input type="checkbox"/> Dizziness / Vertigo	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability / Mood Swings	<input type="checkbox"/> Tension / Stress
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Recurring Infections	<input type="checkbox"/> Diarrhea / Constipation / Gas
<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Shortness of Breathe	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Jaw / TMJ Problems
<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Problems Urinating	<input type="checkbox"/> Heartburn / Reflux
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> PMS	<input type="checkbox"/> Menopause	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood Pressure			
<input type="checkbox"/> Other _____			

Additional Explanation: _____

Have you ever been to a chiropractor? Y / N When was your last adjustment? _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Y N
Was this due to an accident / trauma? Y N
If yes, explain (fall, auto, sports) _____

Symptoms: When this problem is at it's worst, can you explain in your words exactly how it feels?

Severity Mild Moderate Severe
Does this pain travel or radiate? If so, where? _____

Quality: (mark all that apply)
Burning Diffuse Dull / Aching Localized
Sharp Shooting Stabbing Tingling
Radiating Other _____

Is there anything that makes this better or worse? _____

Patient Name: _____

Date: _____

Timing:

- Worse AM Worse PM Worse with activity Worse Sleeping
- Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

Rate the severity of your symptoms or condition on a scale from 1 (Least) to 10 (Severe) _____

Is the condition getting better, worse, or staying the same? _____

How often do you find yourself suffering from this problem? _____

How long does the problem last? _____

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

Carrying groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Changing positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Sit to stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Climbing stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Pet care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Extended computer use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Household chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Lifting children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Reading / Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Self care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Self care – Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Self care – Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Sexual activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Sitting still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Standing still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform

Please list any effects that this may have on any Recreational Activities: _____

Medications: what medications are you currently taking and for what conditions?

Is there anything else you think the doctor should know concerning your condition? Yes _____ No _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (help the symptoms but do not fix the cause of the problem)

_____ Maximum Correction (correct the problem for maximum healing & stability)

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem _____

On a scale of 1-10, ten being the highest, rate how important it is for you and your family to be at their highest health potential _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection. I agree to allow this office to examine me for further evaluation.

Signature

_____/_____/_____
Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore it is best to check children for subluxation and begin any necessary treatment as young as possible.

Duration of Care: While pain relief may only take a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules, correction can range from six months to two years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

Family Check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective Care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness Care: Spinal neglect is so common. It has become an epidemic in our society – despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives, pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child: I, _____, being the parent and legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent / legal guardian: _____ Date: _____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature: _____ Date: _____
