Dr. Phil's 3 Fold Healing
A Chiropractic Practice

DATE_____

PATIENT INFORMATION

First Name:_____Middle Name _____Last Name_____

If patient is under age 18, Parent/Guardian Name:_____

Address:_____City:_____ State:_____Zip:_____

Social Security #:_____Driver's License #:_____

Gender Born With: ____M____F Birth date:_____Age_____

Marital Status: ____Married ____Single ____Domestic Partner Name_____

Number of Children_____ Gender and Ages _____

Occupation:_____Employer/School:_____

Referred by:_____ __Doctor__Family__Friend__Trainer__Other_____

CONTACT INFORMATION

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email Address:_____

Emergency Contact Name(s):_____

Phone:_____Relation to Emergency Contact_____

May we communicate with the above-named emergency contact if needed _____Yes _____No

PATIENT CONDITION

Chief Complaint(s), please list in order of severity: 1:_____

2:_____ 3:_____

Is this visit due to an accident/injury?____Yes____No If yes, is this ____Sports/Activity Related

____Workers Comp Claim ____Personal Injury Case ____Other_____

Date your current symptoms appeared/accident date ___/___/___

How are symptoms changing with time: ___Getting Better ___Not Changing ___Getting Worse

How do you think this problem began?_____

Have you previously had the same condition ___Yes ___No

If yes, please explain:_____

Date of last chiropractic treatment_____Name of Chiropractor_____

How long were you under the care of this Chiropractor?_____

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Number the pain level for the following:

#1 through **#10 (worst)** on each area of chief and secondary complaint.

Type of Pain: ___Stiffness ___ Swelling ___Throbbing ___Numbness ___Dull ___Aching ___Shooting ___Burning ___Tingling ___Cramps ___Sharp___

Other_____

Do you consider this problem to be severe? ___Yes ___No

Explain:_____

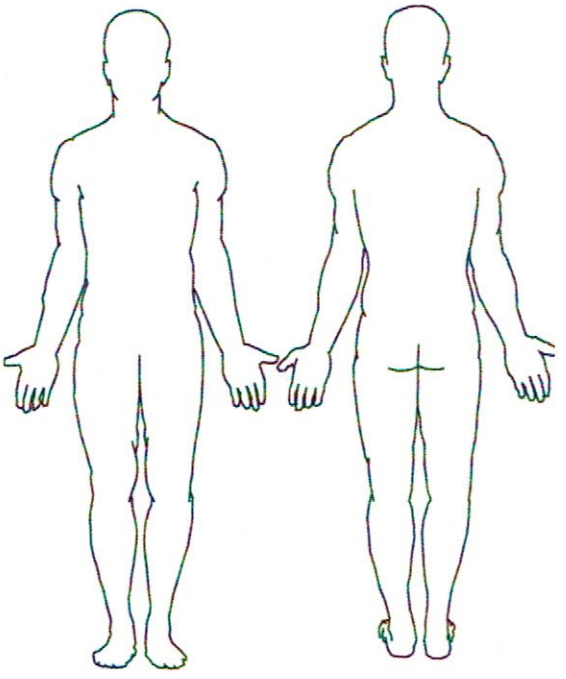
How often do you experience this pain?

___Constantly (76-100% of the time)

___Occasionally (26-50% of the time)

___Frequently (51-75% of the time)

___Intermittently (1-25% of the time)



Front View Back View

Does your pain wake you up at night? ___Yes ___No

Explain_____

Does your pain interfere with your:___Work ___Sleep ___Daily Routine ____Recreation ___Other _____

Activities that make symptoms worse: ___Sitting ___Standing ___Walking ___Bending ___Lying Down Explain_____

Activities that make symptoms better: ___Sitting ___Standing ___Walking ___Bending ___Lying Down Explain_____

Have you seen other practitioners for this injury/condition? (Check all that apply):

___Chiropractor ___ER Physician ___Massage Therapist ___Orthopedist ___Physical Therapist___Primary Care Physician ___Neurologist ____Other:_____

Treatment you already received for your injury/condition: ___Medications ___Physical Therapy ___Chiropractice Services ___None ___Surgery ___Other_____**Name(s) of other practitioner(s) who have treated you for your condition**_____

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MEDICAL HISTORY

Have you ever been treated for any other medical conditions ___Yes ___No

Explain:_____

Date of last physical exam: __/__/__ (if known) **Were there any findings** ___Yes ___No

Explain:_____

***Height:**_____ ***Weight:**_____ ***Normal blood pressure** (if known):_____

Are you pregnant or plan to become pregnant? ___Yes ___No

Have you had recent X-Rays/MRI's/Imaging ___Yes ___No Explain_____

Have you ever (check all that apply):

___ **Broken Bone(s):** If yes, please list all and date of occurrence:_____

_____

___ **Been Hospitalized:** If yes, please list all and date of occurrence:_____

_____

___ **Been in Auto Accident(s):** If yes, please list all, date of occurrence and any injuries_____

_____

___ **Had Sprains/Strains:** If yes, please list all, date of occurrence and treatment required:____

_____

___ **Been Struck Unconscious:** When: _____ For how long:_____

___ **Had Surgery** If yes, please list all and date of occurrence:_____

_____

What medications are you taking and for what conditions? (Please list dosage and frequency):

_____

_____

What vitamins, minerals or herbs do you currently take? (Please list dosage and frequency):

_____

_____

List any family member - present and past health conditions (ex: heart disease, cancer, diabetes, arthritis, etc.):_____

_____

***Can be done during initial visit.**

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SOCIAL INFORMATION

Please indicate, during a typical day, how much of the following you do?

Sit:	___Most of the day	___Half the day	___A little bit of the day
Stand:	___Most of the day	___Half the day	___A little bit of the day
Computer Work:	___Most of the day	___Half the day	___A little bit of the day
On the Phone:	___Most of the day	___Half the day	___A little bit of the day

What type(s) of exercise do you do? Please list all that apply.

Type:_____**Frequency:** ___Less than once a week___1-2 times a week___3-4 times a week ___5-7 times a week **Duration**_____**Intensity Level:** Low - Med - High

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What other activities do you participate in?_____

ADDITIONAL INFORMATION

Please check all that apply:	None	Light	Moderate	Heavy
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Exercize	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____
Soft Drinks	____	____	____	____
Water	____	____	____	____
Salty Foods	____	____	____	____
Sugary Foods	____	____	____	____
Artificial Sweeteners	____	____	____	____
Meat Products	____	____	____	____

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HAVE YOU SUFFERED FROM (Check all that apply):

___AIDS/HIV
___Alcoholism
___Allergies
___Anemia
___Appendicitis
___Arteriosclerosis
___Arthritis
___Asthma
___Back Pain
___Balance Issues
___Bleeding Disorders
___Blood Clots
___Breast Lump
___Bronchitis
___Bruise Easily
___Cancer
___Chemical Dependency
___Chest Pain/Conditions
___Cold Extremities
___Constipation
___Cramps
___Depression
___Diabetes
___Digestion Problems
___Dizziness
___Ears Ringing
___Epilepsy
___Excessive Menstruation
___Eye Pain or Difficulty
___Fatigue
___Fractures
___Frequent Urination
___Glaucoma
___Goiter
___Gout
___Headache
___Heart Disease
___Hemorrhoids
___Hepatitis
___Hernia
___Herniated Disk
___Herpes
___High Blood Pressure
___Hot Flashes
___Irregular Heartbeat
___Irregular Cycle
___Kidney Disease
___Kidney Infection
___Kidney Stones
___Liver Disease
___Loss of Balance
___Loss of Memory
___Loss of Smell
___Loss of Taste
___Measles
___Migraine
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Nausea
___Neck Pain or Stiffness
___Nervousness
___Nosebleeds
___Osteoporosis
___Pacemaker
___Parkinson's Disease
___Pinched Nerve
___Polio
___Poor Posture
___Prostate Trouble
___Psychiatric Care
___Rhuematoid Arthritis
___Rheumatic Fever
___Scarlet Fever
___Sciatica
___Sexually Transmitted Disease
___Shortness of Breath
___Sinus Infection
___Sleep Problems/Insomnia
___Spinal Curvatures
___Stroke
___Swelling of Ankles
___Swollen Joints
___Thyroid Condition
___Tonsillitis
___Tuberculosis
___Tumors, Growths
___Typhoid Fever
___Ulcers
___Varicose Veins
___Venereal Disease
___Vision Changes
___Other (list any/all medical conditions not listed above):

_____

_____

_____

THE ABOVE IS TRUE: (Sign)_____**(Date)**_____

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CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternative to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

1. "While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
2. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal or soft tissue manipulation or treatment.
3. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke,
4. Sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years have demonstrated it to be a highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

1. The condition that the treatment is to address;
2. The nature of the treatment;
3. The risks and benefits of that treatment: and
4. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation, I intend this consent to apply to all my present and future care with: **Dr. Phil Convertino** **Dated this _____ day of _____ 20_____**

_____ _____

Patient Signature (or Legal Guardian) **Signature of Witness**

Print Name:_____ **Print Name:**_____

Doctor's Note: Please be aware that this practice emphasizes Non-force Technique. Simply, we do not twist or crack bones.