Patient History (Please Print) Date:_____________

DIVINE CHIROPRACTIC

Name: _______________________________ Email: ___________________________________

Cell Phone: _______________ Home Phone: _______________ Work Phone: _______________

Address: _______________________________ City: ____________________ Zip: _________

Birth Date: __________ ☐Male ☐Female Spouse's Name: ___________________________

Children #_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Driver's License # ___________

Occupation _____________________ Social Security# : _____________

How were you referred to the Office? ____

Have you ever been under chiropractic care before? _______ If yes, when? _______________

INFORMATION ABOUT THE ACCIDENT/PRESENT INJURY:

Please explain in detail how your accident happened: ______________________________

____

____

____

Were you knocked unconscious? ☐ Yes ☐ No You were struck from: ☐ Behind ☐ Front ☐ Left ☐ Right

You were: ☐ Driver ☐ Passenger ☐ Back seat- left ☐ Back seat - right ☐ Using seat belts

What was the time and date of present injury? ______________________________________

Where did you feel pain immediately after the accident? ______________________________

____

Were you hospitalized? ☐ Yes ☐ No If hospitalized, were you admitted? ☐ Yes ☐ No For how long?_____

What treatment was given? ____

Was any doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _______________ What was the diagnosis? ____________

What treatment was given? ____

What How frequently did you see the doctor? __________ How long did you see the doctor? _________

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? ____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

INSURANCE INFORMATION:

Driver of other vehicle (if any):

Full name: ______________________ Ins. Company: _____________ Claim No. ______________

Driver of vehicle in which you were injured (if any):

Full name: ______________________ Ins. Company: _____________ Claim No. ______________

Name of your insurance adjustor: ______________________ Adjustor fax number: _____________

Adjustor phone number or email: ____

Have you retained an attorney? ☐ Yes ☐ No If yes, what is their name? _________________

If so, what is their email or phone#? __________________________ Fax number? ___________

List your chief complaints in order of severity: Check all those that describe your condition:

Complaint 1: ______________________ For how long? ____________

What originally caused this problem? ______________________

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐ Burning

☐Other: ______________

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

It has been: ☐ Getting worse ☐ Staying the same ☐ Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During the Day it is: ☐ Worse in the AM ☐ Worse in the PM ☐ Stays the same throughout the day

The following **increases** pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other ____________

The following **decreases** the pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other ____________

Does the pain travel/radiate? ☐ Yes ☐ No If yes, where? ______________________

Complaint 2: ______________________ For how long? ____________

What originally caused this problem? ______________________

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐ Burning

☐Other: ______________

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

It has been: ☐ Getting worse ☐ Staying the same ☐ Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During the Day it is: ☐ Worse in the AM ☐ Worse in the PM ☐ Stays the same throughout the day

The following **increases** pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other ____________

The following **decreases** the pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other ____________

Does the pain travel/radiate? ☐ Yes ☐ No If yes, where? ______________________

Complaint 3: ______________________ For how long? ____________

What originally caused this problem? ______________________

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐ Burning

☐Other: ______________

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

It has been: ☐ Getting worse ☐ Staying the same ☐ Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During the Day it is: ☐ Worse in the AM ☐ Worse in the PM ☐ Stays the same throughout the day

The following **increases** pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other ____________

The following **decreases** the pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Walking ☐ Laying Down ☐ Bending ☐ Other ____________

Does the pain travel/radiate? ☐ Yes ☐ No If yes, where? ______________________

List of previous hospital stays/surgeries (what and when?)

____

____

List of any childhood/adult traumas/accidents/falls/auto injuries (what happened and when?)

____

____

____

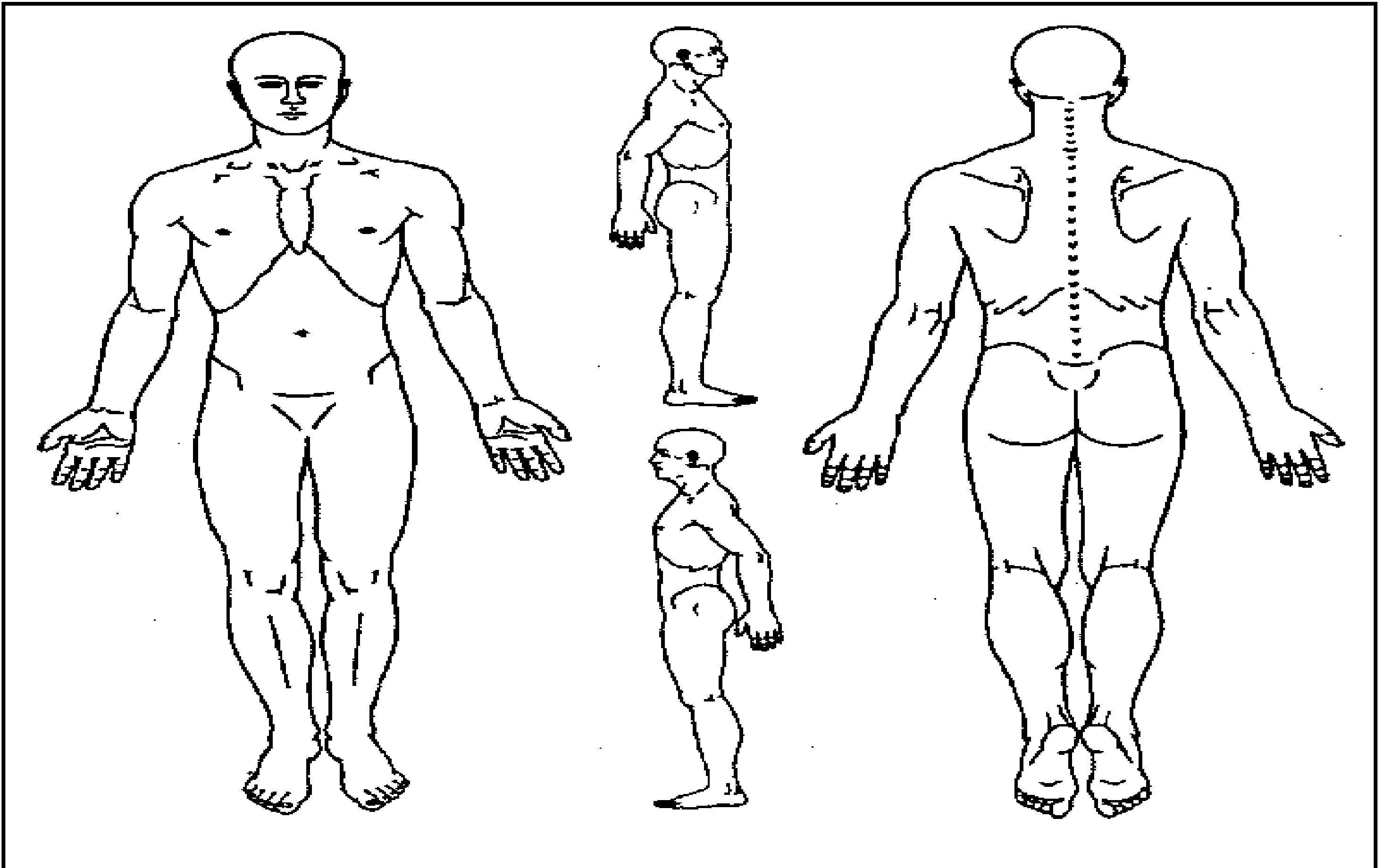
____

Is there anything else you think we should know about you or that you would like to discuss (explain)

____

____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels.



Does your condition interfere with your:

					Goals for Care :
Work	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE	______________________
Sleep	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE	______________________
Daily Routine	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE	______________________
Recreation	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE	______________________

Does your condition interfere with any of the following:

☐ Computer use	☐ Sports	☐ Reading	☐ Exercise	☐ Vacuuming	☐ Social Life
☐ Cleaning	☐ Cooking	☐ Watching Kids	☐ Yard Work	☐ Driving	☐ Relationship
☐ Shopping	☐ Gardening	☐ School	☐ Self Care	☐ Other ______________	

Do you suffer from any of the following conditions currently?

☐ Abdominal aortic aneurysm	☐ AIDS/HIV	☐ Allergy Shots	☐ Asthma
☐ Alcoholism/Drug Abuse	☐ Arthritis	☐ Anemia	☐ Auto immune
☐ Anxiety/Depression	☐ Appendicitis	☐ Anorexia	☐ Allergy Shots
☐ Bleeding Disorders	☐ Bulimia	☐ Buzzing/ringing in ears	☐ Cancer
☐ Chemical Dependency	☐ Cataracts	☐ Chicken pox	☐ Chronic Fatigue
☐ Cold hands/feet	☐ Constipation	☐ Coronary artery disease	☐ Diabetes
☐ Digestive problems	☐ Diarrhea	☐ Dysmenorrhea	☐ Eczema
☐ Erectile Dysfunction	☐ Emphysema	☐ Eye Troubles	☐ Neck pain
☐ Fractures	☐ Gas/Bloating	☐ Glaucoma	☐ Goiter
☐ Gonorrhea	☐ Gout	☐ Heart disease	☐ Headaches
☐ Hepatitis	☐ Hernia	☐ Herniated Disc	☐ Herpes
☐ High cholesterol	☐ Indigestion	☐ Hypertension/HBP	☐ Kidney disease
☐ Kidney stones	☐ Liver disease	☐ Loss of balance	☐ Loss of sleep
☐ Low back pain	☐ Measles	☐ Menstrual problems	☐ Miscarriage
☐ Mid back pain	☐ Mononucleosis	☐ Multiple sclerosis	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's	☐ Pneumonia
☐ Pain/Tingling/Numbness in arms/legs/hands		☐ Prostate problems	☐ Psychiatric care
☐ Rheumatoid arthritis	☐ Sinus problems	☐ Shortness of breath	☐ Shingles
☐ Throat conditions	☐ Suicide attempt	☐ Swollen ankles	☐ Stroke
☐ Thyroid conditions	☐ Tuberculosis	☐ Tumors/growth	☐ Typhoid fever
☐ Unexplained weight gain	☐ Unexplained memory loss		☐ UTI
☐ Unexplained weight loss	☐ Ulcers/colitis/IBS	☐ Vaginal Infection	☐ STI
☐ Whooping cough	☐ Other ______________________________		

Family History (please list all known conditions/illnesses that may apply):

Mother: ______________________________ Father: ______________________________
Grandparents: ______________________________ Siblings: ______________________________

Other known familial conditions:

____

____

For Women only:

Are you Pregnant? ☐ Yes ☐ No Due Date: ______________

Are you Nursing? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Do you have regular cycles? ☐ Yes ☐ No Do you have breast implants?: ☐ Yes ☐ No

Do you experience painful periods? ☐ Yes ☐ No

COVID-19 QUESTIONNAIRE:

Have you been vaccinated? ________

If yes, which vaccine did you receive and when? ______________________

Did you notice any side effects? ______________________

Have you received any boosters? _____

If yes, which boosters did you receive and when? ______________________

Did you notice any side effects? ______________________

Have you had COVID? _________ How many times? ______ When was the last time you had COVID? _____________

Have you had any long-term complaints associated with COVID? (please explain) ______________________

____

____

HEALTH HEABITS:

Do you smoke/vape? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Do you eat organic food? ☐ Yes ☐ No Do you drink soda? ☐ Yes ☐ No

Do you eat processed food? ☐ None ☐ Some ☐ Moderate

CONCERNS: We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and **circle your top 3**

Is it going to hurt?	Is it expensive?	What do I do if chiropractic does not work?
Do I have to come forever?	Are the X-rays dangerous?	What if insurance does not cover chiropractic?
Can this be fixed?	Is it addictive?	I don't want to be cracked

STRENGTHS: Strong habits are key to health: It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and **circle your top 3**

Stretch 3-5 times a week	Exercise 3-5 times a week	Drink ½ my body weight of ounces of water
Take supplements for health	Do activities to minimize stress regularly	Drink or eat something green everyday
Have a positive attitude	Sleep 6-8 hours a night	Get maintenance chiropractic 2-4 x/year
Pray/meditate	Non-smoker	Get maintenance chiropractic 4-8x/year

GOALS: We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant **circle your top 3**

Sleep through the night	Continue working/get back to work	Play with kids/grandkids normally
Exercise again	Avoid future flare ups	Sit/Stand comfortably for an extended period
Get off pain medications	Be ready for an upcoming event	Have some moments of relief
Have a better attitude	Additional Goals: ______________________	

People see Chiropractors for a variety of reasons. Some go in for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Type of Care:

☐ Relief Care: Symptomatic relief of pain or discomfort

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

Authorization for Care and Notice of Privacy

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered. This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception

Patient's Signature: ______________________________ **Date:** ____________________

Printed Name: ______________________________

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits risks and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and /or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctors will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual finding, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not usual, however, you may be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects: i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke, which occurs at a rate between once per one million to one per two million.

Other side effects may include healthier lifestyles, more smiling, increased activity, deeper breathing and feeling younger.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Patient's Signature: ____ **Date:** __________________________

Printed Name: ____