# Lafayette Square Chiropractic Centre

1013 S. 18th Street
Saint Louis, MO 63103

******PLEASE COMPLETE THIS FORM IN BLACK INK******

**Welcome to Our Office!**

**We encourage new practice members to ask all the questions necessary in order to ensure they receive the quality care they need and deserve. We believe that everyone is ultimately responsible for their own health and thus, encourage each patient to be an active participant in their care. We are here to serve you and your family and are *honored* to have the opportunity to do so.**

**Below is an outline of what you can expect during your first few visits at our office. Once you have reviewed it, please complete the attached paperwork. Let us know if you have any questions!**

**DAY ONE: Patient History & Examinations:**

1) **All new patients complete a confidential patient health record, HIPAA forms, and other necessary paperwork.**

2) **Patients then meet with the doctor for a consultation. Diagnostic tests are conducted including chiropractic, orthopedic, and neurological examinations to determine what type of chiropractic care is needed. If x-rays or other out-of-office tests are deemed necessary the patient will be advised of this as well.**

3) **Patients are encouraged to return as soon as possible for their "Report of Findings". The Report of Findings will include testing results and the doctor's individualized recommendations for care. If patients desire, they can also schedule their first adjustment to immediately follow their Report of Findings.**

**DAY TWO: Report of Findings & First Adjustment (optional):**

4) **The doctor and patient review findings and agree on their goals for care (e.g., eliminate pain, maintain current health status, increase health to optimal wellness)**

5) **Insurance coverage, and payment options will also be reviewed with patients at this time.**

6) **Future adjustments/care will be scheduled as determined by the doctor's recommendation and patient choice, and reexaminations will be conducted periodically to determine what phase of health the patient is currently in (e.g., recovery, maintenance, wellness, etc.).**

# CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

## PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____

Address: _____ Sex: ☐ Male ☐ Female

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

Social Security #: _____ Cell Phone: _____

Driver's License #: _____ E-mail Address: _____

Business Employer: _____ Fax #: _____

Occupation: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Employer: _____

Type of Work: _____ Names & Ages of Children: _____

_____ _____

Name & Number of Emergency Contact: _____ Relationship: _____

Who is Responsible for your bill, you and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid

Personal Health Insurance Carrier: _____ Health Card ID#: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Primary Care Physician: _____

Insured Person's Social Security #: _____ Pharmacy: _____

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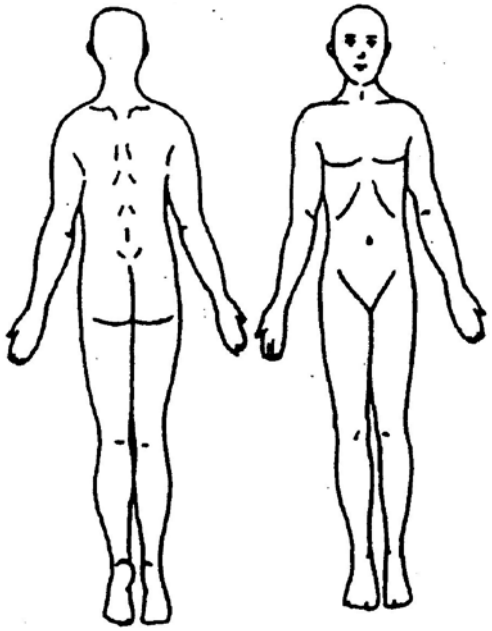
## CURRENT HEALTH CONDITION

Chief Compliant (why you're here today) _____

_____

_____

***PLEASE OUTLINE ON THE DIAGRAM TH AREA OF DISCOMFORT***



When did this condition begin? _____

Has it ever occurred before? ☐ Yes ☐ No

Is Condition: ☐ Auto Related ☐ Work Related ☐ Other ☐ No Injury

Explain: _____

Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work: Have you filled an injury report with your employer? ☐ Yes ☐ No

Claim #: _____

Pain Rating:

☐ Minimal ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe

Functional Impairment (Resting)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Functional Impairment (with Activity)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

**Other doctors seen for this condition?** ☐ Yes ☐ No **Who?** _____

**Type of treatment:** _____ **Results:** _____

**Drugs you take:** ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

☐ Allergy Medication ☐ Ant-Depressants ☐ Other: _____

**Do you wear a shoe lift?** ☐ Yes ☐ No

**Any other conditions you feel we should know about – even if unrelated?** _____

_____

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## REVIEW OF SYSTEMS – Please fill out all sections even if "NONE".

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional:** ☐ None | ☐ Chills<br>☐ Weight Gain | ☐ Daytime Somnolence<br>☐ Weight Loss | ☐ Fatigue | ☐ Fever | ☐ Night Sweats |
| **Eyes/Vision:** ☐ None | ☐ Blindness<br>☐ Eye Pain<br>☐ Photophobia | ☐ Blurred Vision<br>☐ Field Cuts<br>☐ Tearing | ☐ Cataracts<br>☐ Glasses/Contacts | ☐ Change in Vision<br>☐ Glaucoma | ☐ Double Vision<br>☐ Itching |
| **ENT:** ☐ None | ☐ Bleeding<br>☐ Ear Drainage<br>☐ Hearing Loss<br>☐ Nose Bleeds<br>☐ Tinnitus (Ringing in Ears) | ☐ Dentures<br>☐ Ear Pain<br>☐ History of Head Injury<br>☐ PND (Post Nasal Dip)<br>☐ TMJ | ☐ Difficulty Swallowing<br>☐ Fainting<br>☐ Hoarseness<br>☐ Rhinorrhea (Runny Nose) | ☐ Discharge<br>☐ Frequent Sore Throats<br>☐ Loss of Smell<br>☐ Sinus Infections | ☐ Dizziness<br>☐ Headaches<br>☐ Nasal Congestion<br>☐ Snoring |
| **Respiration:** ☐ None | ☐ Asthma<br>☐ Wheezing | ☐ Cough | ☐ Coughing up Blood | ☐ Shortness of Breath (SOB) | ☐ Sputum Production |
| **Cardio:** ☐ None | ☐ Angina<br>☐ Orthopnea<br>☐ Ulcers | ☐ Chest Pain<br>☐ Palpitation s<br>☐ Varicose Veins | ☐ Claudication<br>☐ PND | ☐ Heart Murmur<br>☐ SOB with Exertion | ☐ Heart Problems<br>☐ Swelling of Legs |
| **Gastro:** ☐ None | ☐ Abdominal Pain<br>☐ Difficulty Swallowing<br>☐ Nausea<br>☐ Stool Consistency | ☐ Belching<br>☐ Heartburn<br>☐ Rectal Bleeding<br>☐ Vomiting | ☐ Black Tarry Stools<br>☐ Hemorrhoids<br>☐ Regurgitation<br>☐ Vomiting Blood | ☐ Constipation<br>☐ Indigestion<br>☐ Stool Caliber | ☐ Diarrhea<br>☐ Jaundice<br>☐ Stool Color |
| **Female:** ☐ None | ☐ Breast Lumps/Pain<br>☐ Urine Retention | ☐ Burning Urination<br>☐ Vaginal Bleeding | ☐ Cramps<br>☐ Vaginal Discharge | ☐ Frequent Urination | ☐ Irregular Menstruation |
| **Male:** ☐ None | ☐ Burning Urination<br>☐ Urine Retention | ☐ Erectile Dysfunction | ☐ Frequent Urination | ☐ Hesitancy/Dribbling | ☐ Prostate |
| **Endocrine:** ☐ None | ☐ Cold Intolerance<br>☐ Frequent Urination<br>☐ Voice Changes | ☐ Diabetes<br>☐ Goiter | ☐ Excessive Appetite<br>☐ Hair Loss | ☐ Excessive Hunger<br>☐ Heat Intolerance | ☐ Excessive Thirst<br>☐ Unusual Hair Growth |
| **Skin:** ☐ None | ☐ Changes in Nail Texture<br>☐ Hives<br>☐ Skin Lesions/Ulcers | ☐ Changes in Skin Color<br>☐ Itching<br>☐ Varicosities | ☐ Hair Growth<br>☐ Paresthesias | ☐ Hair Loss<br>☐ Pruritus | ☐ History of Skin Disorder<br>☐ Rash |
| **Nervous:** ☐ None | ☐ Dizziness<br>☐ Loss of Memory<br>☐ Strokes | ☐ Facial Weakness<br>☐ Numbness<br>☐ Tremor | ☐ Headache<br>☐ Seizures<br>☐ Unsteadiness of Gait | ☐ Limb Weakness<br>☐ Sleep Disturbance | ☐ Loss of Consciousness<br>☐ Slurred Speech Stress |
| **Psychologic:** ☐ None | ☐ Anhedonia<br>☐ Confusion | ☐ Anxiety<br>☐ Depression | ☐ Appetite<br>☐ Insomnia | ☐ Behavioral Change<br>☐ Memory Loss | ☐ Bipolar<br>☐ Mood Change |
| **Allergy:** ☐ None | ☐ Anaphylaxis | ☐ Food Intolerance | ☐ Itching | ☐ Nasal Congestion | ☐ Sneezing |
| **Hematology:** ☐ None | ☐ Anemia<br>☐ Fatigue | ☐ Bleeding<br>☐ Lymph Node Swelling | ☐ Blood Clotting | ☐ Blood Transfusions | ☐ Bruising |

## PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

**Childhood Illness:**
☐ None
☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis ☐ Cerebral Palsy
☐ Chicken Pox ☐ Depression ☐ Diabetes ☐ Fetal Drug Exposure ☐ Food Allergies
☐ Headaches ☐ Hepatitis ☐ Measles ☐ Mumps ☐ Rash
☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Spina Bifida ☐ Unusual Childhood Illness

**Adult Illnesses:**
☐ None
☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken Pox
☐ CRPS (RSD) ☐ CVA (Stroke) ☐ Depression ☐ Diabetes (Insulin Dep) ☐ Hypertension
☐ Eye Problems ☐ Heart Disease ☐ Hepatitis ☐ Diabetes (NIDDM – Noninsulin) ☐ Kidney Disease
☐ Liver Disease ☐ Lung Disease ☐ Psychiatric Prot ☐ Seizures ☐ Similar Symptoms
☐ STD's ☐ Suicide Attempts ☐ Thyroid Problems

**Surgeries:**
☐ None
☐ Angioplasty ☐ Appendectomy ☐ Caesarean Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair
☐ Cosmetic ☐ D&C ☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy
☐ Joint Reconstruction ☐ Joint Replacement ☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion
☐ Spinal Fusion ☐ Tonsillectomy

☐ Other : _____

**Ob/Gyn:**
☐ None
Describe: _____

**Injuries:**
☐ None
Describe: _____

**Immunizations:**
☐ None
☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ MMR
☐ Pneumonia ☐ PPD ☐ Small Pox ☐ TD ☐ Varlvax

**Non-Drug Allergies:**
☐ None
Describe: _____

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## FAMILY HISTORY

| | Alive | Deceased | Condition |
|---|---|---|---|
| General Family | ☐ | ☐ | _____ |
| Father | ☐ | ☐ | _____ |
| Mother | ☐ | ☐ | _____ |
| Paternal Grandfather | ☐ | ☐ | _____ |
| Paternal Grandmother | ☐ | ☐ | _____ |
| Maternal Grandfather | ☐ | ☐ | _____ |
| Maternal Grandmother | ☐ | ☐ | _____ |
| Son(s) | ☐ | ☐ | _____ |
| Daughter(s) | ☐ | ☐ | _____ |
| Brother(s) | ☐ | ☐ | _____ |
| Sister(s) | ☐ | ☐ | _____ |

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## SOCIAL HISTORY

**Alcohol:**
☐ None
☐ Beer ☐ Liquor ☐ Social Consumption ☐ Wine Amount: _____

**Diet:**
☐ High Fat Diet ☐ High Fiber ☐ High Protein ☐ High Salt Intake
☐ Low Calorie Intake ☐ Low Carbohydrate ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

**Education:** Level of Degree Attained: _____

**Substance:** ☐ Denies Any ☐ Denies IV Drugs Not Used Since : _____ Used Drugs For: _____

**Tobacco:** Type: _____ Amount: _____