

Bend Chiropractic, Inc. Personal Health History

Name: _____ Spouse's name: _____

Name of parent if minor: _____ Soc. Sec # _____

Address: _____

City: _____ State: _____ Zip: _____ Driver's License: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Business/Employer: _____ E-Mail address: _____

Sex: M F Weight: _____ Height: _____ Birth date: _____

Check one: Single Married Divorced Separated Widow Number of children: _____

How did you hear about us?: _____

Purpose of this Appointment: _____

Previous Chiropractic Care: No Yes: where/when _____

When did this condition begin: _____ Is it Job related Auto related Home accident

Do you ever experience any of these complaints while working? _____ If yes, describe what activities at work that may be causing you to experience these complaints: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers Blood pressure pills Insulin

Other/Over-the-Counter: _____ Women only: Are you pregnant? Yes No

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Spinal Hysterectomy

Broken Bones Other: _____

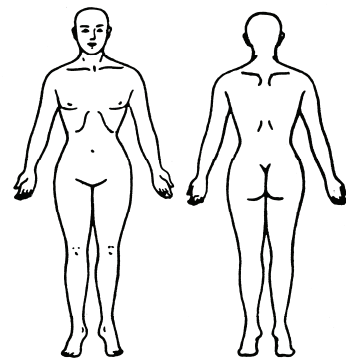
Please check any of the following that give you difficulty or you have had recently.

- Headaches 784.0
- Shooting head pains 784.0
- Sinus Trouble 473.9
- Loss of Smell 781.1
- Allergies 995.3
- Hay fever 477.8
- Asthma 493.9
- Loss of Taste 781.1
- Inflammation of Throat 462
- Thyroid trouble 246.9
- Twitching of face 361.9
- Loss of Memory _____
- Fatigue 780.7
- Depression 31 1.0
- Dizziness 780.4
- Spinal curvature 737.43
- Chest pain 786.5
- Ulcers 534.9
- Earache
- Fainting 780.2
- Loss of balance 781.2
- Ringing in ears 388.3
- Blurred vision 368.0
- Lights bother eyes 368.1 3
- Neck pain 723.1
- Muscle spasms in neck 781
- Grinding in neck 719.68
- Shoulder/arm tightness 728.85
- Shoulder/arm pain 719.4
- Pins & needles in arms 782
- Pins & needles in hands 782

- Cold hands 782
- Numbness in arms/hands 782
- Tonsillitis 784
- Prostate trouble 601.4
- Bed wetting 788.3
- Cancer
- Shortness of breath 786.09
- Mid-back pain 724.1
- Heart attacks 41 0.9
- Low blood pressure 458.9
- High blood pressure 401.9
- Anemia 285.9
- Stomach trouble 789
- Nerves/ nervousness 799.2
- Inner tension 799.2
- Irritability 799.2
- Gall bladder trouble 575.9
- Indigestion 536.8
- Intestinal gas 787.3
- Low back pain 724.2
- Hernia 550.1
- Stroke 436.0
- Arthritis 716.96
- Facial Twitch 781.0
- Numbness in legs/feet 782
- Constipation 564.0
- Kidney trouble 593.9
- Menstrual cramps/pain 625.3
- Menstrual irregularity 626.4
- Diabetes 250.0
- Sleeping problems 780.5

- Painful joints 719.4
- Swollen joints 719.0
- Pins & needles in legs 782
- Swollen ankles 782.3
- Cold feet 782
- Pain in legs/feet 719.46
- Hip pain 719.45
- Facial Pain 784.0
- Jaw Pain (TMJ) 525.9

Please indicate the location of your discomfort with an X mark.



IMPORTANT INFORMATION...Accidents/Falls History (such as auto/work/sport-related/jolts/trauma/etc.):

All events which could have any impact upon the spine are of high significance to determine spinal health history. Please fill out completely.

Within the past year - when: _____

Describe event: _____

Over a year ago - when: _____

Describe event: _____

Childhood - when: _____

Describe event: _____

Hospitalizations (other than above): _____

Who is responsible for your bill? Self Spouse Worker's Comp. Medicare Auto insurance Medi-Cal
Personal Health insurance Other _____

Method of Payment for Initial Visit Charges: Cash Check Visa MC Discover

Name of Insurance co.: _____ Social Security # _____

Phone # of Insurance co.: _____ Your policy # _____

Name policy is under: _____

Bend Chiropractic, Inc. 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, to detect and correct/reduce the vertebral subluxation complex. It is important that each patient understand both the objective and the method that will be used to attain it. 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 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 caused 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 disease or condition other than vertebral subluxation. Regardless of what 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 innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

NOTE: It is understood and agreed the amount paid to Bend Chiropractic Life Center for x-ray, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Consent to Care

I do hereby authorize the doctors of Bend Chiropractic Life Center to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable, and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read, understand and hereby request chiropractic care based on the above agreement.

Signature: _____ Date: _____

Signature of parent or guardian if minor: _____