

**Personal Information**

Title:  Mr.  Ms.  Mrs.  Dr.  Rev.  Miss  Prof.  other: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

In the event we need to contact you, what is the best method of communication? *Phone E-Mail Text*

Children (Names and Ages): \_\_\_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Internet/ YFC website  Yellow pages  Drove by  Physician  Insurance Plan

**Emergency Contact**

Name: \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_

**Employment Information**

Business Name: \_\_\_\_\_

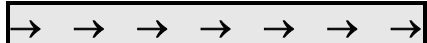
Occupation/Job Title and Description: \_\_\_\_\_

**Current Health Condition**

Unwanted Condition (Why you are here today?): \_\_\_\_\_

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**



Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? \_\_\_/\_\_\_/\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

Is the Condition:  Auto Related  Job Related  Home Injury

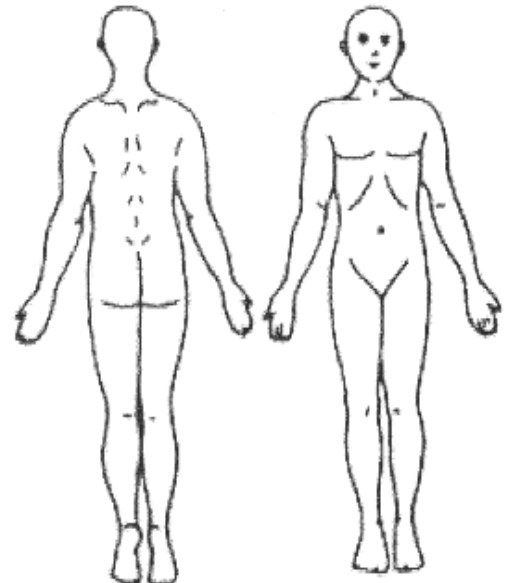
Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am/pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



**Review of Systems:** CIRCLE all CURRENT and PAST conditions. List any health conditions that are not shown below.

Even if a condition seems unrelated to care, please check. These may affect your overall care.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> ADD              | <input type="checkbox"/> cystic kidney disease     | <input type="checkbox"/> high / low blood pressure    | <input type="checkbox"/> psychiatric problems             |
| <input type="checkbox"/> alzheimers       | <input type="checkbox"/> depression                | <input type="checkbox"/> influenzal pneumonia         | <input type="checkbox"/> scoliosis                        |
| <input type="checkbox"/> anemia           | <input type="checkbox"/> diabetes (insulin dep)    | <input type="checkbox"/> liver disease                | <input type="checkbox"/> seizures                         |
| <input type="checkbox"/> arthritis        | <input type="checkbox"/> diabetes (non insulin)    | <input type="checkbox"/> lung disease                 | <input type="checkbox"/> shingles                         |
| <input type="checkbox"/> asthma           | <input type="checkbox"/> eczema                    | <input type="checkbox"/> lupus erythema (discoid)     | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer           | <input type="checkbox"/> emphysema                 | <input type="checkbox"/> lupus erythema (systemic)    | <input type="checkbox"/> STD's (unspecified)              |
| <input type="checkbox"/> cerebral palsy   | <input type="checkbox"/> eye problems              | <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> suicide attempt(s)               |
| <input type="checkbox"/> chicken pox      | <input type="checkbox"/> fibromyalgia              | <input type="checkbox"/> parkinson's disease          | <input type="checkbox"/> thyroid problems                 |
| <input type="checkbox"/> crohn's/colitis  | <input type="checkbox"/> heart disease             | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> dizziness                        |
| <input type="checkbox"/> CRPS (RSD)       | <input type="checkbox"/> hepatitis                 | <input type="checkbox"/> pneumonia                    | <input type="checkbox"/> diarrhea/ constipation:          |
| <input type="checkbox"/> CVA (stroke)     | <input type="checkbox"/> HIV                       | <input type="checkbox"/> psoriasis                    | <input type="checkbox"/> heartburn                        |
| <input type="checkbox"/> anxiety / stress | <input type="checkbox"/> heartburn                 | <input type="checkbox"/> difficulty sleeping          | <input type="checkbox"/> frequent colds                   |
| <input type="checkbox"/> jaw pain         | <input type="checkbox"/> numbness                  | <input type="checkbox"/> fatigue                      |   |
| <input type="checkbox"/> sinus problems   | <input type="checkbox"/> headaches                 | <input type="checkbox"/> currently pregnant           | <input type="checkbox"/>                                  |
| <input type="checkbox"/> ear infections   | <input type="checkbox"/> traumatic birth -your own | <input type="checkbox"/>                              | <input type="checkbox"/>                                  |

**Previous Care for this Same Condition:**

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Were you satisfied with the results of your treatment?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Were you satisfied with your care?  Yes  No. Why? \_\_\_\_\_

Do you wear any of the following?  Heel Lifts  Innersoles  Arch Supports  Orthotics  Other \_\_\_\_\_

**Current Medication (s):** List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you taken?

**Current Vitamins, Herbs, etc:** List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you taken?

**Surgery (ies):** LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> angioplasty             | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy            | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section       | <input type="checkbox"/> dental surgery   | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsillectomy       |
| <input type="checkbox"/> carpal tunnel repair    | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other:              |
| <input type="checkbox"/> coronary artery bypass  | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           | <input type="checkbox"/> other:              |

**Injury (ies):** Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> back injury  | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident    |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |

- disability (ies)
- industrial accident
- soft tissue injury (severe)
- fall (severe)
- joint injury
- other:
- fracture
- laceration (severe)
- other:

**Family History:**

We know that many health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them? \_\_\_\_\_

**Social History: Mark all that apply below.**

- Alcohol:  do not drink alcohol  social consumption only  drink regularly, quantity of \_\_\_\_\_ glasses per \_\_\_\_\_
- My Dietary Intake consists mainly of the following: (mark all that apply)
  - high fat  high salt  low fiber  low sugar  low salt
  - high fiber  low carbohydrate
- Tobacco:  Do not use tobacco  Live with a smoker  Quit smoking  Smoke/ Chew

**Goals For My Care:**

People see Chiropractors for a variety of reasons. Some go for Relief Care, to address their symptom, disease, or condition. Some go to Correct/Stabilize the cause of their symptom, disease, or condition. And some choose Wellness Care, so they can prevent future problems and maximize their health and well-being. Your Doctor will make optimal recommendations, based on your health and what your body needs.

We would like to know what your goals are.

- Relief Care** – Treatment designed to address an obvious symptom, disease, or condition
- Stabilization Care** – Continue with the care necessary to fully heal soft tissues and muscles
- Wellness Care** – Non-symptomatic or maintenance care, designed to maximize optimum spinal and nervous system function and help prevent disease.

**Are we coordinating care with your physician?:**

I would like a copy of my records sent to my physician  YES  NO

(circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other  
 Doctor: \_\_\_\_\_ Clinic's Name and Location: \_\_\_\_\_

**Worker's Comp Information**

Name of Compensation Carrier: \_\_\_\_\_.

Name of Employer: \_\_\_\_\_.

The date of the work related injury was: \_\_\_\_\_.

The time that the injury occurred was: \_\_\_\_\_ a.m. / p.m.

The last date worked was: (month)\_\_\_\_\_/ (day)\_\_\_\_\_/ (year)\_\_\_\_\_.

Were you hospitalized?  Yes  No. If yes, please answer the questions below.

When were you hospitalized?  immediately  later same day  next day  date \_\_\_\_\_

How were you transported to the hospital?  ambulance  life flight  private transportation

What did the hospital recommend?  no instructions  see this clinic  see DC

see own doctor  see orthopedist  see neurologist  prescription medication

other: \_\_\_\_\_

Did you have any xrays taken?  Yes  No

If yes, what areas? \_\_\_\_\_

**My current job status is: (please mark the appropriate response below)**

- off work as a result of the injuries sustained in the reported work accident.**
- working full duty.**
- working light duty.**

**I  have  have not been involved in previous work related accidents/injuries.**

**If you have been involved in previous work related accidents/injuries, please complete below.**

**Status of previous injuries:**

- treated and resolved**
- treated, unresolved, and located at an unrelated area to this accident**
- treated, unresolved, same area as current injury**
- not treated and a completely different area than current injury**
- not treated and still have residual symptoms**
- not treated and do not have any residual symptoms**

**This accident was:  not reported to the employer.  reported to the employer.**

**The name of the employee it was reported to was:\_\_\_\_\_.**

**Employee's Job Title \_\_\_\_\_ Phone # (\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_.**

**The injury occurred at (location): \_\_\_\_\_.**

**How many hours did you work that same day prior to the accident: \_\_\_\_\_.**

**What type of work were you performing at time of injury: \_\_\_\_\_.**

**Describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.**

**I have:**

- been treated by another doctor for the injuries sustained in this accident.**
- not been treated by another doctor for the injuries sustained in this accident.**

**If you have been treated by another doctor, please continue with the following questions. List the doctor's name and current/past treatment: \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_.

**As a result of the treatment received thus far:**

- My condition has improved**
- My condition has not improved**
- My condition has worsened since the injury despite treatment received thus far.**

***Financial Policies:***

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Yost Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Yost Family Chiropractic will be credited to my account upon receipt. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me by Dr. Heather. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card listed below. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If payment hasn't been received in 10 days from terminating care, I authorize deduction from my credit card.

MasterCard/Visa Account # : *Please have available when checking in at front desk.*

***Informed Consent:***

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Yost and/or other licensed doctors of chiropractic who now or in the future work at Yost Family Chiropractic Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consent to treat a Minor: \_\_\_\_\_

Guardian or Spouse's Signature of Authorizing Care: \_\_\_\_\_

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I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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