CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Inspired Health Chiropractic & Wellness
Dr. Jessica Loda

607-256-0641
www.inspiredhealthchiro.com
admin@inspiredhealthchiro.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Age

Gender ○ Male ○ Female Non-Binary

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City

State/Province

ZIP/Postal Code

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

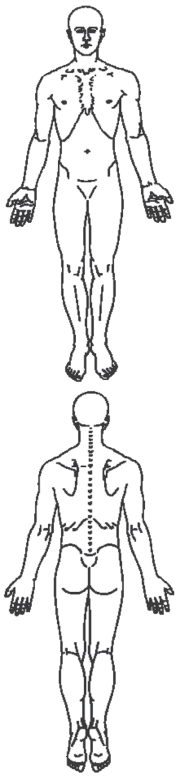
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Dr. Loda know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○ Low energy		Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○ PMS symptoms		Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○ ○ Weakness		Initials ____

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes	No	
○	○	If Yes please list: ____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Loda about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

10. Are there any other hereditary health issues that you know about? ____

11. Social History

Tell Dr. Loda about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? ____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? ____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? ____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? ____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? ____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? ____			

Hobbies: ____

Doctor's Initials

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12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____

14. How much sleep do you average per night? _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ☐ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ☐ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ☐ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ☐ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ☐ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ☐ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Consultation Notes

Patient name

Patient Number
(office use only)

Doctor's Initials

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