# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

**Inspired Health Chiropractic & Wellness**
**Dr. Jessica Loda**
**2359 North Triphammer Road, Suite 1a**
**Ithaca, NY 14850**
**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

**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**

**Insurance Carrier**

**Policy Number**

**Insured's Last Name**

**Birth Date (MM/DD/YYYY)**

**Who carries this policy?** ○ Self ○ Spouse ○ Parent

**Insured's First Name**

**Insured's Middle Name (or Initial)**

**Insured's Employer**

**Address**

**City** | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION



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**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
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Other _____
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat

**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
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Other _____
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat

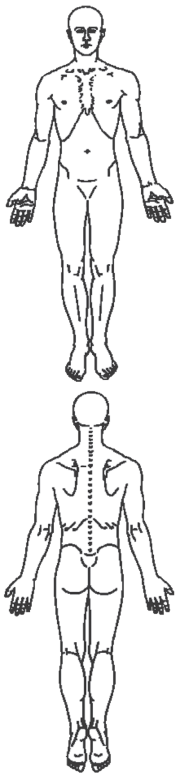
**Additional Complaint**
The additional symptom that prompted me to seek care today is: _____

**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
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Other _____
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat

**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 | | 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 | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anxiety | ◯ | ◯ | Depression | ◯ | ◯ | Headache | ◯ | ◯ | Dizziness | ◯ | ◯ | Pins and needles | ◯ | ◯ | Numbness |

NONE ◯ Initials ____

**c. Cardiovascular**

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

NONE ◯ Initials ____

**f. Sensory**

| Had | Have | | 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 | | 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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*(Continued from previous page)*

**h. Endocrine**

| Had | Have | | 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 | | 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 | | 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**

**Inspired Health**
**Chiropractic & Wellness**



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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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