## ZAO CHIROPRACTIC HEALTH PROFILE

Name_____ Date ___/___/_____ Age_____ Male / Female

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Cell_____ Date of Birth_____/_____/_____

Email Address_____

For confirming appts, would you prefer? TEXT (cell carrier:_____) or EMAIL

Occupation_____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

_____

Who may we thank for referring you? _____

## ***LIST YOUR TOP 5 HEALTH PROBLEMS***

| Health Concerns: List according to severity | Rate of Severity 1 = mild 10 = unbearable | When did this episode start? | If you had the condition before, when? | Did the problem begin with an injury? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

## HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor?_____ Medical Doctor?_____ Other _____

WHO and WHEN? _____

## ***CIRCLE ALL CURRENT PROBLEMS YOU HAVE***

| | | | | |
|---|---|---|---|---|
| *DIZZINESS* | *THROAT ISSUES* | *KIDNEY PROBLEMS* | *LIVER DISEASE* | *NERVOUSNESS* |
| *HEADACHES* | *THYROID PROBLEMS* | *MID BACK PAIN* | *SHOULDER PAIN* | *EPILEPSY* |
| *VERTIGO* | *ASTHMA* | *IRRITABLE BOWEL* | *CHRONIC FATIGUE* | *DISC PROBLEM* |
| *EAR INFECTIONS* | *ULCERS* | *SCIATICA* | *LUPUS* | *INFERTILITY* |
| *NAUSEA* | *NUMBNESS IN ARMS* | *NUMBNESS IN LEGS* | *FIBROMYALGIA* | *GASTRIC REFULX* |
| *TMJ* | *NUMBNESS IN HANDS* | *NUMBNESS IN FEET* | *CHEST PAIN* | *ALLERGIES* |
| *NECK PAIN* | *MENSTRUAL DISORDER* | *LOW BACK PAIN* | *ARM PAIN* | *OTHER*_____ |
| *MIGRAINES* | *HEART DISORDERS* | *HIP PAIN* | *ADD/ADHD* | _____ |
| *ANXIETY* | *STOMACH DISORDERS* | *LEG PAINS* | _____ | _____ |
| *CHRONIC SINUS* | *BLADDER PROBLEMS* | *KNEE PAIN* | _____ | _____ |

## ***CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:***

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEAR_____

_____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT?_____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:_____

_____

_____

## QUADRUPLE VISUAL ANALOGUE SCALE

**Instructions:** Please illustrate the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint with one of the indicated shapes below and indicate the score for each complaint.

**Example:**

Headache △ Neck ○ Low Back □

**No pain** _____ **worst possible pain 0**

**1 2 3 4 5 6 7 8 9 10**

**1 – What is your pain RIGHT NOW?**

**No pain** _____ **worst possible pain**

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

△ _____

**2 – What is your TYPICAL or AVERAGE pain?**

**No pain** _____ **worst possible pain**

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

○ _____

**3 – What is your pain level AT IS BEST (How close to "0" does your pain get at its best)?**

**No pain** _____ **worst possible pain**

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

□ _____

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

**No pain** _____ **worst possible pain**

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

OTHER COMMENTS:_____

_____

_____

**Practice Member's Name**_____ **Practice Member's Signature**_____**Date** _____

# Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITIES: | EFFECT: | | | |
|---|---|---|---|---|
| Carry Children/Groceries | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Stand Up from Sitting | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Climb Stairs | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Pet Care | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Extended Computer Use | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Lift Children/Groceries | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Read/Concentrate | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Get Dressed | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Shave | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sexual Activities | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Fall Asleep | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sleep Through the Night | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sit for a Period of Time | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Stand for a Period of Time | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Yard work | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Walk | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Wash/Bath | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sweep/Vacuum | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Wash Dishes | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Clean Laundry | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Take out Garbage | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Operate Vehicle | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Exercise | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Recreation | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Other: _____ | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Other: _____ | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Other: _____ | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |

****IF ANY ACTIVITY IS <u>NOT PAINFUL BUT HAS BECOME DIFFICULT</u> FOR YOU TO PERFORM or YOU HAVE HAD TO MODIFY HOW YOU PERFORM IT, PLEASE <u>CIRCLE</u> or <u>WRITE-IN</u> THAT ACTIVITY.**

*Example: "Standing up from sitting is not painful, however I now have to use support, so I can stand. "*

**Practice Member's Signature: _____ Date____ /_____ /_____**

## Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by a Doctor of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

**(Practice Member's Signature)** **(Date)**

### *Notice of Privacy Practices Acknowledgement*

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

**(Practice Member's Signature)** **(Date)**

# INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. THE POSSIBILITY OF SUCH INJURIES OCCURRING IN ASSOCIATION WITH UPPER CERVICAL ADJUSTMENT IS EXTREMELY REMOTE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

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**I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.**

_____

**PRINT PRACTICE MEMBER'S NAME HERE**

_____ _____

**PRACTICE MEMBER'S SIGNATURE** **DATE**

***IF PRACTICE MEMBER IS A MINOR/CHILD(UNDER THE AGE OF 18), PARENT OR GUARDIAN MUST SIGN BELOW.***

_____ _____

**SIGNATURE OF PRACTICE MEMBER OR GUARDIAN** **DATE**

_____

**RELATIONSHIP TO MINOR/CHILD**

_____ _____

**WITNESS SIGNATURE (OFFICE STAFF)** **DATE**

## XRAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

**PLEASE NOTE:** IF CLINICALLY NECESSARY X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF ZAO CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
**BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

_____ _____
**PRINT PRACTICE MEMBER'S NAME HERE** **DATE**

_____ _____
**PRACTICE MEMBER'S SIGNATURE** **YOUR AGE**

**FEMALE PATIENTS ONLY:** TO THE BEST OF MY KNOWLEDGE**, I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT ZAO CHIROPRACTIC.

_____ _____
**PRACTICE MEMBER'S SIGNATURE** **DATE**

**DO NOT WRITE BELOW THIS LINE** **DO NOT WRITE BELOW THIS LINE** **DO NOT WRITE BELOW THIS LINE**

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐10-11 | ☐78 | ☐1/24 | 12.5 |
| ☐12-13 | ☐ | ☐1/20 | 15 |
| ☐14-15 | | ☐1/15 | 20 |
| ☐16-17 | | ☐1/10 | 30 |
| | | ☐2/15 | 40 |

MA 300 Size 8x10

☐ Lower Cervical

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐14-15 | ☐70 | ☐1/10 | 20 |
| ☐16-17 | ☐ | ☐2/15 | 30 |
| ☐18-19 | | ☐3/20 | 40 |
| ☐20-21 | | ☐2/10 | 50 |
| ☐22-23 | | | |

MA 300 Size 8x10

☐ APOM

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐14-15 | ☐70 | ☐1/10 | 20 |
| ☐16-17 | ☐ | ☐2/15 | 30 |
| ☐18-19 | | ☐3/20 | 40 |
| ☐20-21 | | ☐2/10 | 50 |
| ☐22-23 | | | |

MA 300 Size 8x10

Other View _____

CM_____Kvp _____

MAS_____MA_____

Size _____

☐ Lateral Thoracic

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐22-23 | ☐80 | ☐1/15 | 20 |
| ☐24-25 | ☐ | ☐1/10 | 30 |
| ☐26-27 | | ☐2/15 | 40 |
| ☐28-29 | | ☐2/10 | 50 |
| ☐30-31 | | ☐1/4 | 75 |
| ☐32-33 | | ☐3/10 | 90 |
| ☐34-35 | | ☐2/5 | 120 |
| ☐36-37 | | ☐1/2 | 150 |

MA 300 Size14x17

☐ A-P Thoracic

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐16-17 | ☐75 | ☐1/20 | 17 |
| ☐18-19 | ☐ | ☐1/15 | 22 |
| ☐20-21 | | ☐1/10 | 30 |
| ☐22-23 | | ☐2/15 | 40 |
| ☐24-25 | | ☐2/10 | 50 |
| ☐26-27 | | ☐1/4 | 75 |
| ☐28-29 | | ☐3/10 | 90 |
| ☐30-31 | | ☐2/5 | 120 |

MA 300 Size14x17

☐ Lateral Lumbar

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐26-27 | ☐88 | ☐2/10 | 30 |
| ☐28-29 | ☐90 | ☐1/4 | 40 |
| ☐30-31 | ☐92 | ☐3/10 | 50 |
| ☐32-33 | ☐94 | ☐2/5 | 70 |
| ☐34-35 | ☐96 | ☐1/2 | 90 |
| ☐36-37 | ☐ | ☐3/5 | 120 |
| ☐38-39 | | ☐4/5 | 160 |
| ☐40-41 | | ☐1 | 200 |
| ☐42-43 | | ☐1 1/2 | |
| | | ☐2 | |

MA 200 Size 14x17

☐ A-P Lumbar

| CM | Kvp | Time | MAS |
|---|---|---|---|
| ☐20-21 | ☐76 | ☐1/15 | 40 |
| ☐22-23 | ☐78 | ☐1/10 | 50 |
| ☐24-25 | ☐80 | ☐2/15 | 75 |
| ☐26-27 | ☐ | ☐2/10 | 90 |
| ☐28-29 | | ☐1/4 | 120 |
| ☐30-31 | | ☐3/10 | 150 |
| ☐32-33 | | ☐2/5 | 120 |
| ☐34-35 | | ☐1/2 | 170 |
| ☐36-37 | | ☐3/5 | 210 |
| ☐38-39 | | ☐4/5 | |
| ☐40-41 | | ☐1 | |
| ☐42-43 | | ☐1 1/2 | |
| | | ☐2 | |

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____
_____

**CA Initials:**

_____

# FAMILY HEALTH HISTORY

Please make indications with an 'X'. This form is vital to the doctor. By providing current and past family health history information, you are ensuring that the doctor has all the information necessary to provide the most accurate and best care possible.

| CONDITION | FATHER | MOTHER | DAUGHTER | SON | SPOUSE |
|---|---|---|---|---|---|
| ARM PAIN | | | | | |
| ARTHRITIS | | | | | |
| ASTHMA | | | | | |
| ADD/ADHD | | | | | |
| ALLERGIES | | | | | |
| BACK TROUBLE | | | | | |
| BED WETTING | | | | | |
| CANCER | | | | | |
| CARPAL TUNNEL | | | | | |
| DECEASED | | | | | |
| DIABETES | | | | | |
| DIGESTIVE PROBLEMS | | | | | |
| DISC PROBLEMS | | | | | |
| EAR INFECTIONS | | | | | |
| FIBROMYALGIA | | | | | |
| HEADACHES | | | | | |
| HEARTBURN | | | | | |
| HIGH BLOOD PRESSURE | | | | | |
| HIP PAIN | | | | | |
| LEG PAIN | | | | | |
| MENSTRUAL DISORDER | | | | | |
| MIGRAINES | | | | | |
| NECK PAIN | | | | | |
| SCOLIOSIS | | | | | |
| SHOULDER PAIN | | | | | |
| SINUS TROUBLE | | | | | |
| TMJ | | | | | |

_____ _____ _____/_____/_____

Print Practice Member Name | Practice Member's Signature | Date