ASBURY FAMILY Chiropractic

2100 Asbury Road, Suite #6 Dubuque, IA 52001 (563) 582-3424

Last_____First_____Birth Date_____Social Security #:_____

Address_____City_____ST_____Zip_____

Phone (H)_____(C)_____Email_____

Occupation_____Employer_____

Spouse's Name_____D.O.B_____Spouse Ph_____

Children's Name & Ages_____

Have you had previous Chiropractic care? □yes □no

Who may we thank for referring you to our office?_____

Who is your primary care physician?_____Phone:_____Date of last physical?_____

May we update your medical doctor regarding your treatment in our office? □yes □no

Please provide as much detail as possible.

Current Complaint:_____Date when symptom first appeared_____

How did it begin:_____

Have you ever experienced the same or similar symptoms? □yes □no When?_____

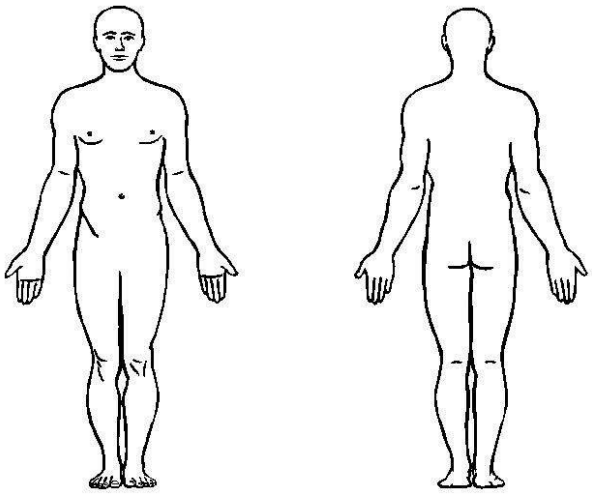
Have you been to another doctor for this problem? □yes □no Who?_____

Type of Pain: □Sharp □Dull □Ache □Burn □Throb □Other Do you have numbness/tingling? ☐yes ☐no Where?_____

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate

What makes the symptoms increase?_____What relieves the symptoms?_____

Do any family members suffer from the same complaint? If so, who?_____



Please mark off all areas of complaint on the diagrams with the following indicators:

AAA=ache DDD=dull NNN=numbness
TTT=tingling BBB=burning SSS=sharp/stabbing
XXX=other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0••1••2••3••4••5••6••7••8••9••10

Please list all surgeries, injuries, accidents, falls, etc: _____

_____

List all Medications/Vitamins:_____

Do you smoke? ☐yes ☐no How many packs per week?_____ If in the past, when did you quit?_____
Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week?_____
Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day?
Do you exercise? ☐yes ☐no If yes, how many times per week and what type?_____
Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Health History- Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis
Asthma	Bleeding	Breast Lump	Bronchitis	Bulimia	Cancer
Cataracts	Chicken pox	Depression	Diabetes	Emphysema	Epilepsy
Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx
Liver dx	Measles	Migraines	Miscarriage	Mono	M.S.
Mumps	Osteoporosis	Parkinson's	Polio	Pacemaker	Pacemaker
Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke
Thyroid	Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers
V.D.	Whooping Cough	Chronic Fatigue	High BP	Fibromyalgia	

Other_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

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 the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. 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 doctors feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I also had an 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 resent condition and for any future condition(s) for which I seek treatment. **Initial_____**

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Asbury Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Asbury Family Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payers to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Patient balances may not exceed $200 at any time. **Initial_____**

Patient's Signature_____ Date:_____

Guardian's Signature_____ Date:_____