River Valley Chiropractic

104 BURNSIDE AVE. SO. RED WING, MN 55066

ABOUT THE PATIENT

Name _____Date_____

Address_____City_____ State_____Zip_____

Home phone _____ Cell phone_____ Birth date _____ Age_____ Gender _____

Number of children _____ Approximate Height_____Approximate Weight_____Marital Status _____

Employer_____Work phone_____Type of work_____

Social Security #_____E-mail address_____ Payment ❑ Cash ❑ Check ❑ Credit card

As a Gonstead Chiropractic office, we focus on what the overall causes affecting your health are. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will help to restore you to your optimum health.

ABOUT YOUR SPOUSE

Name _____

Employer _____

Work phone _____

Type of work _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name_____

Approximate date of last visit _____

Has any adult in your family seen a Chiropractor?

❑ Yes ❑ No

Has any child in your family seen a Chiropractor?

❑ Yes ❑ No

MEDICATIONS I NOW TAKE

❑ Nerve pills
❑ Stimulants
❑ Tranquilizers
❑ Muscle relaxers
❑ Insulin
❑ Blood pressure medicine
❑ Blood thinners
❑ Pain killers (including aspirin)
❑ _____
❑ _____

On a scale of 1-10 describe your stress level (1=none / 10=extreme) Occupational_____Personal_____

REASON FOR THIS VISIT

What is your primary concern for this visit _____

_____

When did this condition begin? _____

How did this condition begin?_____

_____

Has this condition

❑ gotten worse ❑ stayed constant ❑ comes and goes

Describe your complaint(s):

❑ Achy ❑ Burning ❑ Dull ❑ Numb ❑ Sharp
❑ Shooting ❑ Stiff ❑ Tingling ❑ Mild
❑ Moderate ❑ Severe ❑ Constant ❑ Intermittent

Does this condition interfere with

❑ Work ❑ Sleep ❑ Daily routine ❑ Other activities

Please explain _____

Has this condition occurred before? ❑ Yes ❑ No

Please explain _____

Have you seen other doctors for this condition? ❑ Yes❑ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

What else have you tried to help improve your current health complaint?_____

_____

Has anyone else in your family experienced similar symptoms? ❑ Yes ❑ No If yes, who_____

_____

What concerns you the most about your condition; what does it prevent you from doing?_____

_____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- Doctors of Chiropractic work with the nervous system? ❑ Yes ❑ No
- The nervous system controls all bodily functions and systems? ❑ Yes ❑ No
- Chiropractic is the largest natural healing profession in the world? ❑ Yes ❑ No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❑ Yes ❑ No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh you needs and desires when recommending you treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ I am only concerned about relief of a particular symptom.

❑ I am only concerned about relief of a particular symptom, and preventing its return.

❑ I want optimum health and well being on every level available to me.

❑ I want the Doctor to select the type of care appropriate for my condition.

_____

Patient's signature Date

HEALTH HABITS

	No	Yes	
Do you smoke?	❑	❑	How Much_____
Do you drink alcohol?	❑	❑	How Much_____
Do you drink coffee?	❑	❑	How Much_____
Do you drink pop?	❑	❑	How Much_____
Do you exercise regularly?	❑	❑	❑ Strenuous ❑ Moderate ❑ Light
Are you exposed to toxic chemicals?	❑	❑	List_____
Do you have any Air borne allergies?	❑	❑	List_____
Do you have any food allergies?	❑	❑	List_____
Do you take vitamins or minerals?	❑	❑	Lists_____

Do you wear ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

Rate your overall health: ❑ Excellent ❑ Very good ❑ Fair ❑ Poor

What is your definition of health?_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Heart Problems	❑	❑	Diarrhea
❑	❑	Fainting	❑	❑	Stroke	❑	❑	Heartburn
❑	❑	Sinus problems	❑	❑	Loss of balance	❑	❑	Problem urinating
❑	❑	Dizziness	❑	❑	Loss of smell	❑	❑	Kidney problems
❑	❑	Sleeping problems	❑	❑	Loss of taste	❑	❑	Hepatitis
❑	❑	Pain between shoulders	❑	❑	High/Low blood pressure	❑	❑	Thyroid problems
❑	❑	Neck pain	❑	❑	Difficulty breathing	❑	❑	Ringing in ears
❑	❑	Numbness in Arms/legs/hands	❑	❑	Asthma	❑	❑	Tension
			❑	❑	Depression	❑	❑	Psychiatric problems
❑	❑	Pain in Arms/legs/hands	❑	❑	Irritability	❑	❑	Cold hands/feet
			❑	❑	Mood Swings	❑	❑	Cancer
❑	❑	Lower back problems	❑	❑	Diabetes			
❑	❑	Arthritis	❑	❑	Digestive problems			
❑	❑	Joint Pain/Stiffness	❑	❑	Ulcers/Colitis			

For women:

Are you pregnant?	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No
Are you taking birth control?	❑ Yes	❑ No
Do you experience painful periods?	❑ Yes	❑ No
Do you have irregular cycles?	❑ Yes	❑ No
Have you experienced hot flashes?	❑ Yes	❑ No

Significant Trauma(s): _____

Surgeries:_____