FREEDOM SQUARE CHIROPRACTIC

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COMPREHENSIVE HISTORY & INTAKE INFORMATION

Personal

Name ____ Date ___________ Birth Date ___________ Age _____ Height ________ Weight ________

Marital Status: ❑Married; name of spouse ________________________ ❑Single ❑Separated ❑Divorced ❑Widowed No. of Children _________

Employer ____________________________ Work Phone___________________ Occupation ___________________ SS# ____________________

Home Address ____ City ________________________ State _______ Zip____________

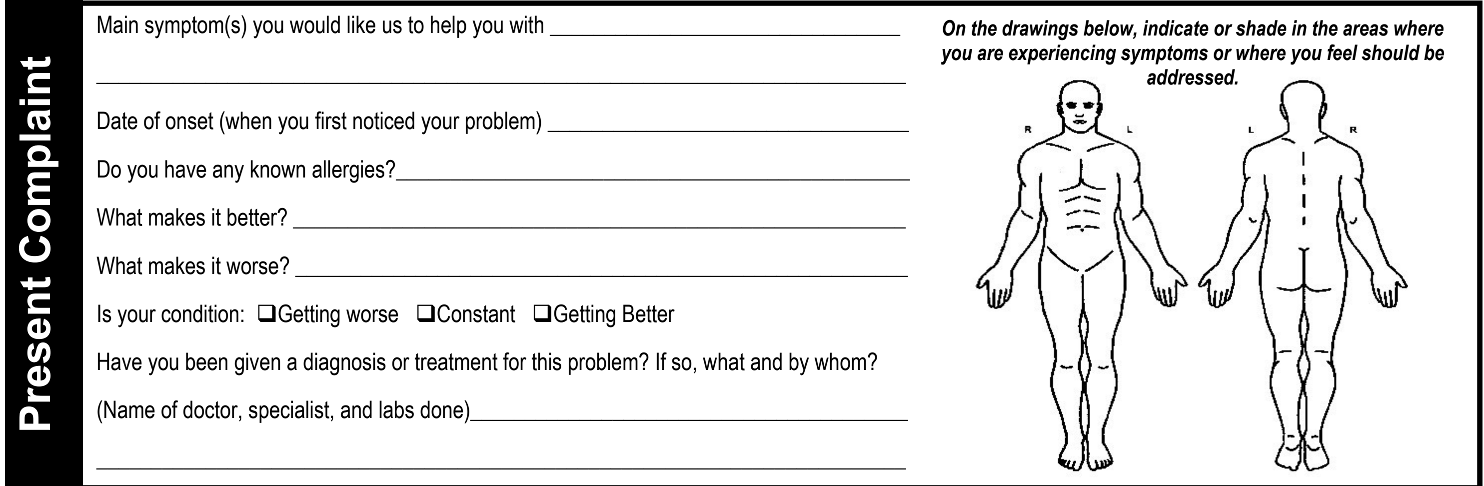
Home Phone ____________________ Cell Phone ____________________ Cell Carrier __________Email __________________________________

Which method is best to contact you for office reminders or promotional information: ❑Text ❑Email

Emergency Contact _____________________________________ Phone ______________________ Work or Cell Phone ____________________

Referred by ____ How did you hear about us? ____

Present Complaint



Main symptom(s) you would like us to help you with ______________________________

____

Date of onset (when you first noticed your problem) ______________________________

Do you have any known allergies?____

What makes it better? ____

What makes it worse? ____

Is your condition: ❑Getting worse ❑Constant ❑Getting Better

Have you been given a diagnosis or treatment for this problem? If so, what and by whom?

(Name of doctor, specialist, and labs done)______________________________________

____

On the drawings below, indicate or shade in the areas where you are experiencing symptoms or where you feel should be addressed.

Informed Consent

❑ **M.S.A. & N.A.E.T.** *(meridian stress assessment & allergy elimination therapies)* — I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose. I understand that M.S.A. & N.A.E.T. is not a medical diagnostic procedure and therefore does not diagnose a disease and that M.S.A. / N.A.E.T. uses various standard, proven measures and modalities to ascertain the patient's condition and gives the practitioner an indication as to the substances(s) to which the patient may have a sensitivity. I choose to be tested electrodermally and/or using kinesiological methods. I understand that electrodermal testing has not been scientifically proven to be reliable and that my practitioner must still rely on my observations as to the efficacy of the test and any treatment based on the results of this test. I understand that other methods of allergy testing and treatment are available.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Freedom Square Chiropractic regarding cure or improvement of my condition. I hereby release Freedom Square Chiropractic from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

Patient Name *(print clearly)* _________________________________ **Patient Signature X**____________________________ **Date** _____________

Patient Guardian *(complete only if patient is under 18 years of age)*

Name ________________________________ Relation __________________ Signature ___________________________ Date _______________

Responsibility

Name of Responsible Party ____________________________________Date of Birth__________________ SS# _______________________

Address *(if different from above)* ____ City/State/Zip ______________________________

I authorize care and treatment by **Freedom Square Chiropractic**, their associates, and health care providers. I understand that payment is due prior to each visit and hereby agree to pay my account as services are provided. If payment is not received from either an insurance company or family within 30 days, I agree to pay 1.5% INTEREST CHARGES PER MONTH (18% ANNUAL INTEREST) on all unpaid balances over 30 days. Should any unpaid balances be referred to a collection agency, I agree to pay an additional collection fee (30-50% of AMOUNT DUE) plus reasonable attorney's fees. I also authorize releases of all information to insurance or other third party carriers and direct them to remit payments directly to the attending doctor. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I may request Freedom Square Chiropractic to bill my insurance company on my family's behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. **We require 24 hours notice for cancelled appointments.** You may be charged a $25 fee for missed appointments, or dismissed from the practice. This office charges a $25 fee in addition to the check amount for each check returned by your bank.

Signature X____ **Date** ______________________________

Medical History

Check the following conditions you have or have had:

- ❑ AIDS / HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Birth Trauma
- ❑ Cancer
- ❑ Chicken pox
- ❑ Cold sores
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Eczema
- ❑ Edema
- ❑ Epilepsy
- ❑ Fever blisters
- ❑ Fibromyalgia
- ❑ Goiter
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis A/B/C
- ❑ Herpes
- ❑ Hypertension
- ❑ Influenza
- ❑ Lyme's disease
- ❑ Malaria
- ❑ Measles
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Sinus infections
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Whooping cough

General Symptomatic History

Check any of the following symptoms or conditions that have been persistent in the last three months:

General

- ❑ Fevers
- ❑ Chills
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot)
- ❑ Thirst, no desire to drink
- ❑ Fatigue
- ❑ Sudden energy drop
  Time of day? ________
- ❑ Poor sleeping
- ❑ Edema
  Where? ____________
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Poor appetite
- ❑ Weight gain
- ❑ Weight loss

Skin & Hair

- ❑ Rashes
- ❑ Itching
- ❑ Change in hair or skin
- ❑ Ulcerations
- ❑ Eczema
- ❑ Oozing on skin lesion
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff
- ❑ Other:__________________

Head, Eyes, Ears, Nose & Throat

- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
  When? ____________
  Where? ____________
- ❑ Facial pain
- ❑ Glasses or contact lenses
- ❑ Poor vision
- ❑ Color blindness
- ❑ Blind field
- ❑ Eye pain
- ❑ Eye strain
- ❑ Spots in front of eyes
- ❑ Cataracts
- ❑ Eye dryness
- ❑ Excessive tear
- ❑ Discharge from eyes
- ❑ Poor hearing
- ❑ Ringing in ears (Tinnitus)
- ❑ Earaches
- ❑ Discharge from ear
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Nasal drainage
- ❑ Grinding teeth
- ❑ Teeth problems
- ❑ Jaw clicks
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Hoarseness
- ❑ Sores on lips or tongue
- ❑ Other:__________________

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest discomfort /pain
- ❑ Heart palpitations
- ❑ Cold hands or feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Fainting
- ❑ Difficulty in breathing
- ❑ Discharge from ear
- ❑ Other:__________________

Respiratory

- ❑ Cough
- ❑ Asthma/wheezing
- ❑ Pain with a deep breath
- ❑ Difficulty breathing
- ❑ Production of phlegm
  What color? ________
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Other:__________________

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Bad breath
- ❑ Heartburn
- ❑ Belching
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Chronic laxative use
- ❑ Blood in stools
- ❑ Black stools
- ❑ Abdominal pain or cramps
- ❑ Gas
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Other:__________________

Genito-Urinary

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Blood or in urine
- ❑ Decrease in flow
- ❑ Unable to hold urine
- ❑ Dribbling
- ❑ Kidney stones
- ❑ Impotency
- ❑ Change of sexual drive
- ❑ Sores on genitals
- ❑ Other:__________________

Musculoskeletal

- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Back pain
- ❑ Elbow pain
- ❑ Hand/wrist pains
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pains
- ❑ Muscle pains
- ❑ Muscle weakness

Neuropsychological

- ❑ Seizures
- ❑ Areas of numbness
- ❑ Weakness
- ❑ Sleep disorder
- ❑ Concussion
- ❑ Bad temper
- ❑ Loss of control/violence
- ❑ Vertigo
- ❑ Lack of coordination
- ❑ Depression
- ❑ Susceptible to stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse
- ❑ Other:__________________

Family History

Check all that apply to your extended family:

- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Eyes/vision
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ High blood sugar
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Other:__________________

Habits

Please rate your involvement with the following habits.

N = None
L = Light
M = Moderate
H = Heavy

	Rating
Alcohol	
Coffee	
Tobacco	
Drugs (+ R_x)	
Sleep	
Appetite	
Soft drinks	
Salty foods	
Water	
Sugar	