

**Gentle Chiropractic, LLC**  
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**Phone: 314-537-1461**

**Patient Data Sheet:**

**Date** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Ph.: (\_\_\_\_) \_\_\_\_\_ Work Ph.: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ May we contact you via email? \_\_\_\_\_

Gender: M F Not Specified Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: S M D W Partner

# of Children \_\_\_\_\_, ages \_\_\_\_\_

Name of Spouse or Partner. Minors, Name of Parent or Guardian: \_\_\_\_\_

Age: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone :(\_\_\_\_) \_\_\_\_\_ Cell Phone :(\_\_\_\_) \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone number: \_\_\_\_\_

Your Work Status: Full time Part time Retired

List chiropractors you have seen previously \_\_\_\_\_

How did you find us, and may we thank someone for referring you?

\_\_\_\_\_

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I understand that payment is due in full at time of service unless prior arrangements have been made. Fees are based on upon individual services and may vary from visit to visit.**

**I agree to pay in full at the time of service and will file my own insurance. Reimbursement is determined by my contract with my insurance company.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health History:**

Alcohol: \_\_\_\_\_  
Soda/diet soda: \_\_\_\_\_  
Coffee/tea: \_\_\_\_\_  
Sweetener: \_\_\_\_\_

Drinks/day

Water intake  64+ oz  32-64 oz  
(per day)  16-32 oz  8-16 oz  
 < 8 oz  
(1 glass = 8-12 oz)

Tobacco: Packs/day \_\_\_\_\_

Stress level:  High  Mod  Low

Sleep:  8+ hrs  6-8 hrs  4-6 hrs  < 4

Exercise:  5-7x/wk  3-5x/wk  1-3x/wk  
 none Type \_\_\_\_\_

Meals/day:  5  4  3  2  1

Veggies and fruits/day:  5  4  3  2  1

**Diet:**

-Do you feel your diet is adequate? Y N

-Are you on a special diet or particular diet? Y N

If yes explain \_\_\_\_\_

-How long has it been since you felt really good?  Days  Weeks  Months  Years

-What is your general state of health?  Excellent  Good  Fair  Poor

-Please rate how serious you are about getting well (scale of 1-5, 5=Serious) \_\_\_\_\_

-Please rate how serious you are about staying well (scale of 1-5, 5=Serious) \_\_\_\_\_

-Are you willing to follow a treatment plan designed to help you return to health? Y N

-Are you willing to take supplements and make dietary changes? Y N

**Medications:** Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
<input type="checkbox"/> Antacids	_____	_____
<input type="checkbox"/> Antibiotics	_____	_____
<input type="checkbox"/> Anti-depressants	_____	_____
<input type="checkbox"/> Anti-diabetics	_____	_____
<input type="checkbox"/> Anti-inflammatory	_____	_____
<input type="checkbox"/> Blood pressure lowering meds	_____	_____
<input type="checkbox"/> Cholesterol lowering meds	_____	_____
<input type="checkbox"/> Hormone Replacement (HRT)	_____	_____
<input type="checkbox"/> Oral contraceptives	_____	_____
<input type="checkbox"/> Over-the-Counter	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> Other	_____	_____

Do you take **vitamins/supplements** or **herbs**?

Please list: \_\_\_\_\_

**Allergies:** Please list all allergies.

- Food: \_\_\_\_\_
- Medications: \_\_\_\_\_
- Seasonal/other: \_\_\_\_\_

**Surgical Procedures/Scars:** List all major surgeries, date performed, and scar location. \_\_\_\_\_

**Hospitalizations:** Describe reason for hospitalization, date, and treatment. \_\_\_\_\_

**Automobile Accidents:** List date, injuries, and treatment. \_\_\_\_\_

**Other Accidents:** Describe accident (eg. fractures, dislocations, bad falls, sprains, head injuries). \_\_\_\_\_

**Family History:**

Please mark with an “X” any illnesses that **you** have *now* or have had in the past. Identify any conditions your family members have now or have had in the past. G = Grandparents, M = Mother, F = Father, S = siblings

- |                                                                |                                                             |
|----------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Immune system problems             |
| <input type="checkbox"/> Blood pressure problems               | <input type="checkbox"/> Tumors: non-cancerous              |
| <input type="checkbox"/> Heart disease                         | <input type="checkbox"/> Cancer                             |
| <input type="checkbox"/> Anemia <i>or</i> other blood disorder | <input type="checkbox"/> HIV/AIDS                           |
| <input type="checkbox"/> Diabetes <i>or</i> hypoglycemia       | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Kidney disease                        | <input type="checkbox"/> History of Sexual Abuse            |
| <input type="checkbox"/> Bladder problems                      | <input type="checkbox"/> History of Physical Abuse          |
| <input type="checkbox"/> Gall bladder problems                 | <input type="checkbox"/> Cold sores                         |
| <input type="checkbox"/> Hepatitis                             | <input type="checkbox"/> Alcoholism                         |
| <input type="checkbox"/> Colon disease                         | <input type="checkbox"/> Drug Abuse                         |
| <input type="checkbox"/> Ulcers                                | <input type="checkbox"/> Deep vein thrombosis               |
| <input type="checkbox"/> Headaches                             | <input type="checkbox"/> Epilepsy                           |
| <input type="checkbox"/> Emphysema                             | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Gout                                  | <input type="checkbox"/> Osteoporosis                       |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> Pneumonia                             | <input type="checkbox"/> Diagnosed Psychological Disorder   |
| <input type="checkbox"/> Tuberculosis (TB)                     | Explain: _____                                              |
| <input type="checkbox"/> Muscle disorders                      |                                                             |
| <input type="checkbox"/> Neurological Problems                 |                                                             |

**Symptoms:** Please mark “P” (past) or “C” (current), and circle any that are of particular concern.

*General*

- Convulsions
- Confusion
- Dizziness
- Fatigue
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats
- Weakness in limbs
- Fever
- Irritability
- Scoliosis
- Arthritis

*Muscles and Joints*

- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Tremors
- Foot Trouble
- Painful Tailbone
- Pain between Shoulders
- Hernia
- Spinal Curvature

*Gastro-intestinal*

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching
- Foul Gas
- Nausea
- Vomiting

*General*

- Vomiting of Blood

*Women Only:*

- Painful Periods
- Excessive Flow
- Irregular cycle
- Hot Flashes
- Cramps or Backache

- Pain Over Stomach
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids
- Liver Trouble
- Jaundice
- Gall Bladder Trouble

*Cardiovascular*

- Rapid Heart
- Slow Heart
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Stroke
- Poor Circulation
- Ankle Swelling
- Hardening of Arteries

*EENT*

- Poor Vision
- Light hurts Eyes
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Ear Discharge
- Nasal Obstruction
- Nose Bleeds
- Sore Throats
- Horseness
- Hay Fever
- Asthma
- Frequent Colds
- Enlarged Thyroid
- Tonsillitis
- Sinus Trouble

- Loss of Smell or taste

*Skin*

- Skin Eruptions
- Itching
- Bruise Easily
- Dryness
- Boils
- Sensitive Skin
- Eczema
- Varicose Veins

*Respiratory*

- Chronic Cough
- Spitting Blood
- Spitting Phlegm
- Chest Pain
- Difficulty Breathing

*Genito-urinary*

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infection
- Bed Wetting
- Inability to control urine

Do you have regular bowel movements?  Yes  No  
\_\_\_\_\_x's day or week

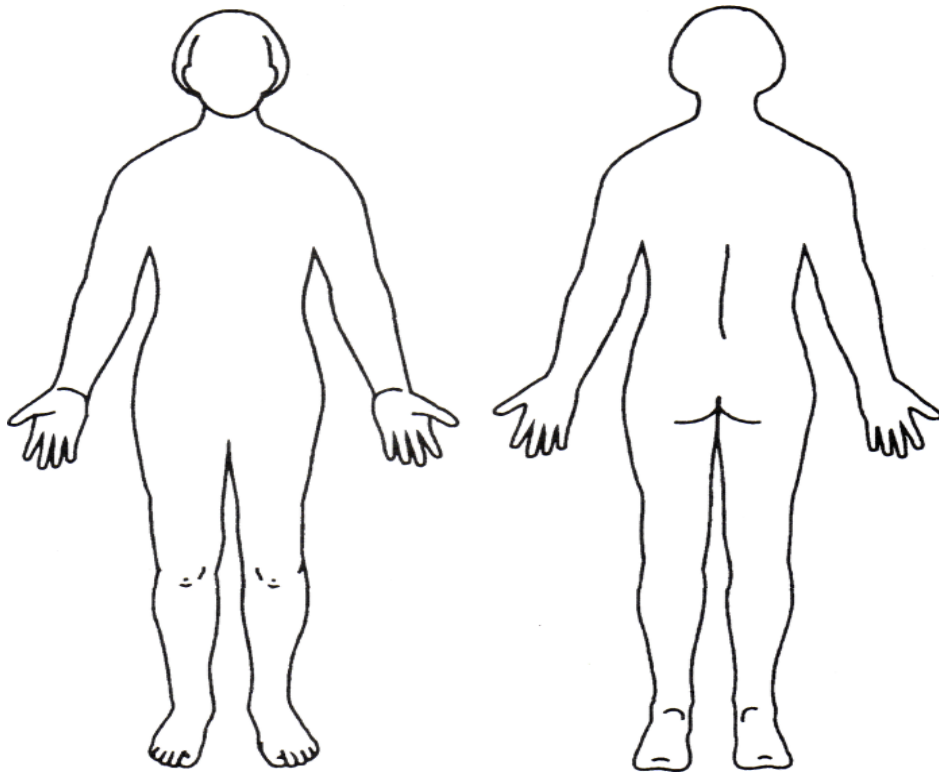
Any change in bowel or bladder habits recently?  
 Yes  No

*Men Only:*

- Prostate trouble
- Decreased Libido

**Health Concerns:** Please list your top health concerns in order of priority.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_



On a scale of 1 to 10, with 1 representing minimal pain, and 10 representing unbearable pain, how would you rate your pain? \_\_\_\_\_

-Is your concern a result from:  an auto accident?  an injury at work?  another accident?

-Has another doctor treated you for this condition?  Y  N

When? \_\_\_\_\_

Type of treatment \_\_\_\_\_

-Is this condition interfering with your:  Work  Sleep  Daily Routine  Recreation  
 Family  Other: \_\_\_\_\_

-What do you believe is wrong with you? \_\_\_\_\_

Your initials and date: \_\_\_\_\_