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 Nonbinary Preferred pronouns:_____

Date of Birth: _____ Your Age:_____

Marital Status: Single Married Divorced Widowed Partnered
# of Children_____, ages_____

Name of Spouse or Partner: _____ Age: _____

Your Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

In case of emergency contact: _____
Relationship: _____Phone number:_____

Your Work Status: Full- time Part-time Not Employed Self-Employed 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 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/day: _____ Tobacco: Packs/day _____ Soda/diet soda: _____
Stress level: □ High □ Mod □ Low Coffee/tea: _____ Sweetener: _____
Sleep: □ 8+ hrs □ 6-8 hrs □ 4-6 hrs □ < 4 Exercise: □ 5-7x/wk □ 3-5x/wk □ 1-3x/wk
Type of exercise_____
Water intake: □ 64+ oz □ 32-64 oz □ 16-32 oz □ 8-16 oz (1 glass = 8-12 oz) □ < 8 oz □ none
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 a 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
□ Antacids _____	_____
□ Antibiotics _____	_____
□ Antidepressants _____	_____
□ Anti-diabetics _____	_____
□ Anti-inflammatory _____	_____
□ Blood pressure lowering meds _____	_____
□ Cholesterol lowering meds _____	_____
□ Hormone Replacement (HRT) _____	_____
□ Oral contraceptives _____	_____
□Over-the-Counter _____	_____
□ Other _____	_____
□ 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

___ Arthritis
___ Blood pressure problems
___ Heart disease
___ Anemia *or* other blood disorder
___ Diabetes *or* hypoglycemia
___ Kidney disease
___ Bladder problems
___ Gallbladder problems
___ Hepatitis
___ Colon disease
___ Ulcers
___ Headaches
___ Emphysema
___ Gout
___ Asthma
___ Pneumonia
___ Tuberculosis (TB)
___ Muscle disorders
___ Neurological Problems
___Familial trauma
___ Immune system problems
___ Tumors: non-cancerous
___ Cancer
___ HIV/AIDS
___ Anxiety
___ History of Sexual Abuse
___ History of Physical Abuse
___ Cold sores
___ Alcoholism
___ Drug Abuse
___ Deep vein thrombosis
___ Epilepsy
___ Stroke
___ Osteoporosis
___ Sexually Transmitted Disease (STD)
___ Diagnosed Psychological Disorder
Explain:_____
___ Other_____

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

___Convulsions
___ Confusion
___ Dizziness
___ Fatigue
___ Loss of sleep
___ Loss of weight
___ Nervousness
___ Numbness

___ Sweats
___ Weakness - 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
___ Vomiting of Blood
___ Pain Over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble
___ Decreased Libido

Cardiovascular
___ Rapid Heart
___ Slow Heart
___ Hypertension
___ Low Blood Pressure
___ Pain over Heart
___ Stroke
___ Poor Circulation
___ Ankle Swelling
___ Hardened Arteries

EENT
___ Poor Vision
___ Light hurts Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharge
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throats
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Thyroid disease
___ 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

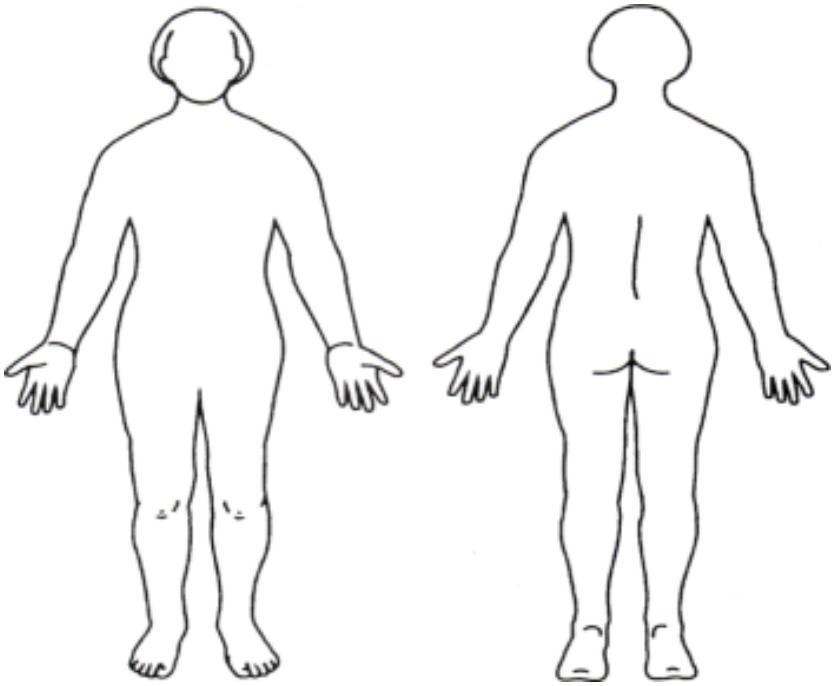
Any changes in bowel or bladder habits recently? □ Yes □ No
Do you have regular bowel movements? □ Yes □ No
_____x's day or week

Women Only:___ Painful Periods ___ Miscarriage ___ Excessive Flow ___ Vaginal Discharge ___ Irregular cycle ___ Fertility Problems ___ Hot Flashes ___ Cramps or Backache □ Yes □ No
Pregnant? □ Yes □ No
Nursing? □ Yes □ No

Men Only: ___ Prostate trouble

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? □ other 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:_____