



# PARADIGM CHIROPRACTIC

Time \_\_\_\_\_ RM \_\_\_\_\_

T 1 2 3

Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Male / Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Cell Phone Provider \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_

Single / Married / Divorced / Widowed Spouse's Name \_\_\_\_\_

Number of Children \_\_\_\_\_ Names, Ages & Gender \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ Office Only \_\_\_\_\_

### LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor? \_\_\_\_\_ Medical Doctor? \_\_\_\_\_ Other \_\_\_\_\_

Who and When? \_\_\_\_\_

### CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	DISC PROBLEM
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	INFERTILITY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHRONIC FATIGUE	LUPUS
EAR INFECTIONS	ULCERS	SCIATICA	FIBROMYALGIA	OTHER _____
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	GASTRIC REFLUX	_____
TMJ	NUMBNESS IN HANDS	NUMBNESS IN FEET	CHEST PAIN	_____
NECK PAIN	LOW BACK PAIN	ARM PAIN	MENSTRUAL DISORDER	_____
MIGRAINES	HEART DISORDERS	HIP PAIN	ADD/ADHD	_____
ANXIETY	STOMACH DISORDERS	LEG PAIN	NERVOUSNESS	_____

CIRCLE ANY CONDITION YOU HAVE NOW / HAVE HAD

STROKE    CANCER    HEART DISEASE    SPINAL SURGERY    SEIZURES    SPINAL BONE FRACTURE    SCOLIOSIS    DIABETES

List all surgical operations and years: \_\_\_\_\_  
\_\_\_\_\_

List all over the counter & prescription medications you are on: \_\_\_\_\_  
\_\_\_\_\_

When was your last auto accident? \_\_\_\_\_

Have you had previous chiropractic care?    YES / NO

If you have, Dr. & date: \_\_\_\_\_

Have you ever been knocked unconscious? YES / NO    Fractured a bone? YES / NO

If yes, please describe: \_\_\_\_\_

Other trauma: \_\_\_\_\_  
\_\_\_\_\_

**Social History**

1. **Smoking:** \_\_\_cigars    \_\_\_pipe    \_\_\_cigarettes → How often? \_\_\_Daily    \_\_\_Weekends  
\_\_\_Occassionally    \_\_\_Never

2. **Exercise:** How often? \_\_\_ Daily    \_\_\_Weekends    \_\_\_Occasionally    \_\_\_Never

3. How does your present problem affect the following: **Hobbies --- Recreational Activities --- Exercise**

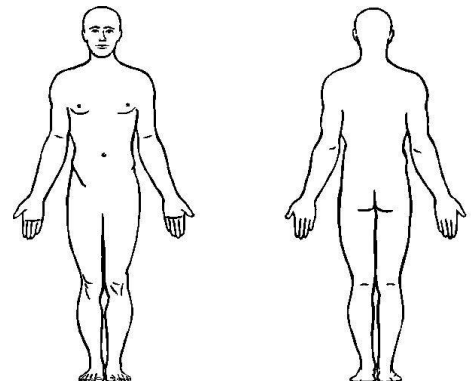
4. **What daily activities are being restricted by your current health problems:**  
\_\_\_\_\_  
\_\_\_\_\_

**\*Please Mark** the areas on the Diagram with the following **letters** to describe your symptoms:

**R=**Radiating    **B=**Burning    **D=Dull**    **A=Aching**    **N=Numbness**    **S=Sharp/Stabbing**  
**T=Tingling**

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_



## Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform



- **Consultation-** includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and or static palpation, leg check \$50-\$100
- **Chiropractic Adjustment-** The actual realignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$30-\$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. \$50 per view.

### **Release of Authorization/Assignment of Benefits**

I authorize and request payment of insurance benefits directly to Paradigm Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. I understand that all professional services rendered are charged to the patient and that it is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by the assigned and that Paradigm Chiropractic reserves the right to add a \$25.00 service charge to my account for any returned check or charge back. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Terms of Acceptance**

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.



IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A CHILD \_\_\_\_\_

I AUTHORIZE Dr. SAM SAWYER AND THE PARADIGM CHIROPRACTIC STAFF TO PERFORM  
DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE,  
AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY  
AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY PARADIGM  
CHIROPRACTIC.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
GUARDIAN SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO MINOR / CHILD

# Family Health History

This form is to assist the doctor by providing past health history information for their review.

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

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

CONDITION	SPOUSE	SON	DAUGHTER	FATHER	MOTHER
Arm Pain					
Arthritis					
Asthma					
ADD/ADHD					
Allergies					
Back Trouble					
Bed Wetting					
Cancer					
Carpal Tunnel					
Diabetes					
Digestive Problems					
Disc Problems					
Ear Infections					
Fibromyalgia					
Headaches					
Heartburn					
High Blood Pressure					
Hip Pain					
Leg Pain					
Menstrual Disorder					
Migraines					
Neck Pain					
Scoliosis					
Seizures					
Shoulder Pain					
Sinus Trouble					
TMJ					