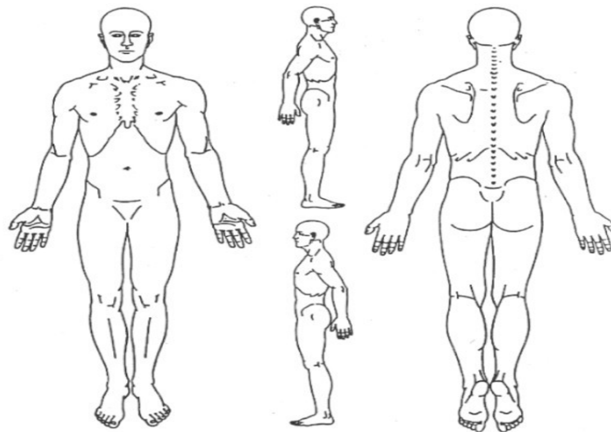
Name: ______________________________ **Date:**___________ **Date of Birth**_____________
How would you like to be addressed? ________________ Referred by: ____________________
Age:________ Sex: M / F Social Security# _______________________Status: S M W D
Address: _________________________________ City:____________ State:_____ Zip: ________
Home# ______________________ Work#______________________ Cell#__________________
E - mail address:____________________________________Occupation:_________________
Employer:_____________________________________FT / PT Work Zip:_________________
Name of spouse: ____________________ Spouse's employer:_______________________FT / PT
Name & number of emergency contact: ________________________ Relationship: ___________
Names & ages of children:____
Purpose of this appointment:____
Name of your M.D. : ______________________________ Phone #: ___________________
Is condition: Job / Auto Accident related? ____
Type of treatment: ________________Date of accident: ______ Attorney:___________________
Phone#_______________________ Have you made a report of your accident? Yes / No
Prior surgeries/date:____
When was your last physical exam?____
How often do you drink alcoholic beverages? ____________________ Do you smoke? Yes / No
Do you exercise? Yes / No How often? _________________ Type? ______________________
List current medications:____

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters: ***(next to the letter put a number from 1-10 with 10 being severe)***

A: ache **B:** burning **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Which pain or condition is bothering you the most?_____________________________________
____

Patient_______________________________ Date_____________

On the scale below, please circle the **severity** of your **chief complaint** (at it's worst):

None	**Slight**		**Mild**		**Moderate**			**Severe**		
0	1	2	3	4	5	6	7	8	9	10

On the scale below please circle the **percentage of time** you experience your main complaint:

	Occasional			**Intermittent**		**Frequent**			**Constant**	
0	10	20	30	40	50	60	70	80	90	100%

When did this problem start? ____

What do you think might have caused it?_______________________________________

What makes it feel better? __________________________Worse? _______________________

Is it worse in the morning or evening?__________ Does it keep you up at night? Yes No

Does the pain radiate, or stay in one area?______________________________________

Have you ever had this problem in the past? _________ If so when?_________________________

Does anyone in your family suffer from a similar condition? Yes No

Problems of the above nature can be caused by **subluxation**, which are alterations in normal spinal biomechanics. Research has shown these spinal shifts can irritate the central nervous system, which can lead to many seemingly unrelated health problems (digestive problems, cardiac problems, headaches, etc.). To help us determine if you're suffering from subluxation please check any of the following that apply and fill in the blank following it:

- Car accident (when?)_________________ ☐ Feet hurt/shoe wear uneven?_________________
- ☐ Slips/ falls (recent?)__________________ ☐ Neck/back pain on long car rides?_____________
- ☐ Sleeping with big pillow(s)____________ ☐ Poor posture________________________________
- ☐ Computer/desk work>1 hr/day?_________ ☐ Emotional stress ___________________________
- ☐ Broken bones/concussions _____________ ☐ Sports injury________________________________

Health status/cause of death: mother________________________ father_____________________

Siblings:____

Children:____

Any family diseases that might relate to Chief Complaint?________________________________

Any hereditary diseases?____

Honestly rate your diet over the past 6 months:

1 2 3 4 5 6 7 8 9 10

Very Unhealthy **Very Healthy**

Very Unhealthy = mostly processed foods (boxed, canned, drive-thru's), lunchmeats, non-organic meats, hydrogenated snacks (peanut butter, chips, crackers, cookies), white flour/bread, milk

Very Healthy = mostly raw organic vegetables, fruits, nuts & seeds, occasional organic meats

I drink ________ 8 oz. glasses of pure water daily.

Supplements I take: ____ None ____ Questionable Quality ____ Good Quality ____ Outstanding Quality

Brand & Type of Vitamin: ____

The percentage of the time I feel: ____ No Stress _____ Some Stress _____ High Stress _____ Extreme Stress (must add up to 100%)

HEALTH HISTORY

Patient:____ Date: ______________________

Have you ever suffered from or been diagnosed as having:

Never Previously Currently		Never Previously Currently		Never Previously Currently	
o o o	ADD / ADHD	o o o	Dizziness	o o o	Muscular Dystrophy
o o o	Arthritis	o o o	Epilepsy	o o o	Osteoporosis
o o o	Alcoholism	o o o	Fibromyalgia	o o o	Polio
o o o	Allergies	o o o	Headaches	o o o	Rheumatic Fever
o o o	Cancer	o o o	Hepatitis	o o o	Rheumatoid Arthritis
o o o	Concussion	o o o	HIV	o o o	Tuberculosis
o o o	Diabetes	o o o	Measles	o o o	Tumors
o o o	Digestion Problems	o o o	Multiple Sclerosis	o o o	Ulcers

SYSTEMS REVIEW

Please check at least one box for each sign or symptom listed. (Never, Previously or Currently)

Never Previously Currently	**GENERAL SYMPTOMS**	Never Previously Currently	**GASTRO-INTESTINAL**	Never Previously Currently	**EYE/EAR/NOSE/ THROAT**	Never Previously Currently	**RESPIRATORY**
o o o	Chills	o o o	Belching/Gas/Bloating	o o o	Crossed Eyes	o o o	Asthma
o o o	Fatigue	o o o	Abdominal Pain	o o o	Deafness	o o o	Bronchitis
o o o	Fever	o o o	Constipation	o o o	Earache	o o o	Wheezing
o o o	Headache	o o o	Diarrhea	o o o	Ear Discharge	o o o	Chest Pain
o o o	Loss of Sleep	o o o	Excessive Eating	o o o	Ear Noises	o o o	Chronic Cough
o o o	Loss of Weight	o o o	Gall Bladder Trouble	o o o	Tinnitus (ringing in ears)	o o o	Difficulty Breathing
o o o	Neuralgia	o o o	Hemorrhoids (piles)	o o o	Enlarged Thyroid	o o o	Coughing Blood
o o o	Sweats	o o o	Rectal Bleeding	o o o	Frequent Colds	o o o	Coughing Phlegm
		o o o	Jaundice	o o o	Hay Fever		
	CARDIO-VASCULAR	o o o	Liver Trouble	o o o	Hoarseness		**GENITO-URINARY**
o o o	High Blood Pressure	o o o	Nausea	o o o	Nasal Obstruction	o o o	Bed-Wetting
o o o	Low Blood Pressure	o o o	Stomach Pain	o o o	Nosebleeds	o o o	Blood in Urine
o o o	Pain Over Heart	o o o	Poor Appetite	o o o	Pain in Eyes	o o o	Frequent Urination
o o o	Poor Circulation	o o o	Poor Digestion	o o o	Poor Vision	o o o	Lack of Bladder Control
o o o	Heart Trouble	o o o	Vomiting	o o o	Sinusitis	o o o	Kidney Infection
o o o	Rapid Heart Rate	o o o	Vomiting Blood	o o o	Sore Throat	o o o	Painful Urination
o o o	Slow Heart Rate	o o o	Excessive Thirst	o o o	Tonsillitis	o o o	Prostate Trouble
o o o	Pacemaker	o o o	Indigestion	o o o	Persistent Cough		
o o o	Strokes			o o o	Difficulty Swallowing		**FOR WOMEN ONLY**
o o o	Swelling Ankles		**NERVOUS**	o o o	Bleeding Gums	o o o	Cramps or Backaches
o o o	Varicose Veins	o o o	Convulsions			o o o	Excessive Flow
		o o o	Dizziness		**SKIN OR ALLERGIES**	o o o	Hot Flashes
	Muscles/Joints/Bones	o o o	Fainting	o o o	Boils	o o o	Irregular Cycle
o o o	Backache	o o o	Nervousness	o o o	Bruising Easily	o o o	Miscarriage
o o o	Foot Trouble	o o o	Depression	o o o	Dryness	o o o	Painful Periods
o o o	Hernia	o o o	Cold Extremities	o o o	Eczema	o o o	Vaginal Discharge
o o o	Pain Between Shoulders	o o o	Tingling Extremities	o o o	Hives or Allergy	o o o	Lump In Breast
o o o	Painful Tail Bone	o o o	Anxiety	o o o	Itching	oYoN	Pregnant at this time?
o o o	Stiff Neck	o o o	Seizures	o o o	Sensitive Skin	________	Last Mammogram Date
o o o	Spinal Curvature			o o o	Skin Eruptions	________	Last Pap Date
o o o	Swollen Joints						
o o o	Tremors/Twitching						
o o o	Arm Trouble						

Are you currently receiving treatment for any of the above conditions?

____

____

Terms of Service

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.
HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I, (Printed name)_______________________________(Signature)____
undertake any care with the understanding of and agreement with, the above explanation. __________________(Date).

Consent to evaluate and adjust a minor and/or child: I,______________________________(Print Name) being the parent or legal guardian of _________________________________(Print name) give permission for my child to receive any care.

***How we protect your Health Information*:**

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HEALTHCARE PURPOSES

By signing this Consent, I acknowledge and provide permission to Platinum Wellness (Practice) as follows:
1. Platinum's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice reserves the right to not treat me.
I have read and understand the health information disclosure and protection in the foregoing notice.

______________________________ PRINTED Name

______________________________ SIGNATURE

______________________________ DATE

______________________________ *Signature of Legal Guardian (e.g. if a minor)*

______________________________ *Relationship to minor*