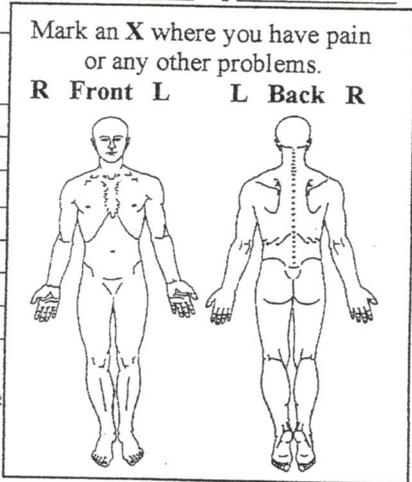
PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS
IF YOU HAVE DIFFICULTY, PLEASE ASK FOR ASSISTANCE

Patient's Name ______________________________ Today's Date ____/____/____
Address ______________________________ City ______________ State ____ Zip ________
Age ______ Birth date ____/_____/______ Sex ☐M ☐ F Status M S W D No. Children ________
Home Phone (___)_____-________ Cell Phone (___)_____-________ Email (optional)______________
Work Phone (___)_____-__________Social Security xxx-xxx-______________
Occupation ______________________ Employer ______________________ Years Employed______
Work Address ______________________ City ______________ State _____ Zip ____________
Spouse's Name ______________ Employer ______________________________
Person Responsible for this Account ______________________ Health Plan ______________
Subscriber's Name ______________________ ID# ______________ Group # ______________
Emergency information: Nearest relative not living with Name ______________________
Address: ______________________________ City:______________________St__________Zip___
______

Home Phone (____)______-________ Work Phone (____)_____-________Cell Phone (____)_____-________
Referred: Who referred you to our office?______________________________
Family doctor: Who is your regular family doctor?______________________________
Doctor's address: ______________________City ______________ St. __________Zip________
The date your problem began: _____/_____/_____
What caused this problem? Is it ☐ work-related ☐ an auto injury? ☐I don't know
____
____
____



Please describe your complaint-______________________________
____
____
____

Pain intensity: (Circle the number that describes your pain at its highest level)
no pain 0 1 2 3 4 5 6 7 8 9 10 **worst pain I can imagine**
very little pain **moderate pain** **severe pain**

What percentage of the hours that you are awake are your symptoms present?
☐ 0-25%, occasional ☐ 26-50%, intermittent ☐ 51-75%, frequent ☐ 76-100%, constant

What makes it feel worse?______________________________
____
What makes it feel better?______________________________
____

In the past week, how much did your problem interfere with your ability to perform your daily activities?
(Circle the number that best describes your level of difficulty)
no interference 0 1 2 3 4 5 6 7 8 9 10 unable to carry on any daily activities
very little **some** **moderate** **severe**

What activities or limitations do you have at home now? ______________________________
____
____

List or attach a list of any medications you are currently taking, prescription or other, including birth control, vitamins, herbs, over-the-counter, etc. - ☐None ______________________________
____
____

Have you received any treatment for this problem? ☐No ☐Yes, When, what type of treatment, and the results?
____
____

Have you had any ☐X-rays, ☐MRI or ☐CT scans, or other tests for this condition? ☐No ☐Yes If so, when and at what facility?____

Have you missed any days from work? ☐No ☐Yes How many? _________ Last day worked was ___/___/____

Are you able to work now? ☐ No ☐ Yes, ☐ Regular Work or ☐ Modified Work until ____/____/_____

If you had any of the listed symptoms in the past, please check that symptom in the **Past Column**.

If you are currently having any of symptoms, please check that symptom in the **Now Column**.

Past	Now	Symptom:
☐	☐	Headache
☐	☐	Neck Pain
☐	☐	Shoulder Pain ☐R ☐L
☐	☐	Upper arm or elbow pain ☐R ☐L
☐	☐	Wrist pain ☐R ☐L
☐	☐	Hand Pain ☐R ☐L
☐	☐	Pain in fingers ☐R ☐L
☐	☐	Upper back pain
☐	☐	Lower back Pain
☐	☐	Hip or upper leg pain ☐R ☐L
☐	☐	Lower leg pain ☐R ☐L
☐	☐	Knee Pain ☐R ☐L
☐	☐	Ankle pain ☐R ☐L
☐	☐	Foot pain ☐R ☐L
☐	☐	Pain in toes ☐R ☐L
☐	☐	Jaw pain ☐R ☐L
☐	☐	Joint swelling
☐	☐	Joint stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Dermatitis/eczema
☐	☐	Nervous System Disorders
☐	☐	Epilepsy / Seizures

Past	Now	Symptom:
☐	☐	Visual Disturbances
☐	☐	Fever
☐	☐	Convulsions
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (ear noises)
☐	☐	High blood pressure
☐	☐	Rapid Heartbeat
☐	☐	Shortness of breath
☐	☐	Chest pain
☐	☐	Heart attack, Date_____
☐	☐	Stroke, Date _________
☐	☐	Aneurysm, ___________
☐	☐	Blood disorders
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Chronic Cough
☐	☐	Loss of appetite
☐	☐	Abnormal weight gains
☐	☐	Abnormal weight loss
☐	☐	General Fatigue
☐	☐	Excessive Thirst
☐	☐	Diabetes, ___________
☐	☐	Abdominal pain
☐	☐	Difficulty Swallowing
☐	☐	Heartburn/indigestion

Past	Now	Symptom:
☐	☐	Stomach or intestinal Ulcers
☐	☐	Liver/gallbladder problems
☐	☐	Hepatitis, Type _______
☐	☐	Constipation/irregular bowel habits
☐	☐	Irritable Bowel
☐	☐	Colitis
☐	☐	Irregular Menses
☐	☐	Excessive Menses
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Breast ☐soreness ☐lumps
☐	☐	Loss of bladder control
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Bladder infections
☐	☐	Prostate Problems
☐	☐	Kidney stones
☐	☐	Kidney disorders
☐	☐	HIV/AIDS
☐	☐	Tumors
☐	☐	Depression
☐	☐	Cancer ___________ ___________

Are you Pregnant? ☐No ☐Yes, Due Date _____/_____/_____

Do you have vertigo (dizziness)? ☐No ☐Yes

Do you pass out easily (faint, loss of consciousness)? ☐No ☐Yes

Do you have any slurred speech or difficulty with speech? ☐No ☐Yes

Do you have or have you ever had difficulty in arranging words properly? ☐No ☐Yes

Have you had any difficulty walking, with coordination or falling to one side? ☐No ☐Yes

Do you have any nausea or vomiting? ☐No ☐Yes

Do you have any numbness on one side of your face or body? ☐No ☐Yes

If a family member has had any of the following, please mark the appropriate box:
☐Cancer ☐Rheumatoid arthritis ☐Lupus ☐Diabetes ☐Nervous disorders ☐Lung problems ☐Heart problems ☐High blood pressure ☐Chronic headaches ☐Chronic back problems Other: ____________________

Past Injuries--Please list all major past accidents or injuries (include concussions, head injuries, broken bones, slip and falls, auto accidents, work injuries, etc) you may have had - ☐None, Please describe the accident, or injury and when it occurred. Also please list any residual problems that resulted: ____________________

____

____

Past Surgical History--Please list all surgeries/operations you have ever had. Please list any implants, stimulators, medicated pumps, metal/titanium/steel implants and their location. - ☐None

____

____

____

Past Hospitalizations--Please list all hospitalizations you have had in the past which **DID NOT** involve surgery. Also list any residual problems you attribute to these illnesses. ☐None

____

____

____

Are you currently receiving care for any other health problems of any kind at this time? ☐No ☐Yes What?

____

____

____

Social History

☐Past ☐ Now Caffeine (☐Coffee ☐Tea ☐Chocolate ☐Soft drinks) cups/cans per day: ________
☐Past ☐Now Smoke ___________packs/day When did you quit? ____________________
☐Past ☐ Now Alcohol ___________/day When did you quit? ____________________

Occupational History: ☐ Currently working ☐ Retired ☐ Unemployed
Do you have a permanent Disability Rating? ☐No ☐Yes Location of disability: ____________________
Date Rating Received: ____________________ Rating Percentage: ____________________

I VERIFY THAT ALL OF THE ABOVE IS COMPLETED TO THE BEST OF MY KNOWLEDGE. I AGREE TO NOTIFY THIS OFFICE IMMEDIATELY WHENEVER I HAVE CHANGES IN MY HEALTH CONDITION OR HEALTH PLAN COVERAGE IN THE FUTURE.

I AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION TO MY PRIMARY CARE PHYSICIAN AND/OR THE REFERRING OR REFERRED TO PHYSICIAN, WHICHEVER AND WHENEVER IT IS APPROPRIATE, REGARDING MY CURRENT AND ANY FUTURE CARE THAT I MAY RECEIVE IN THIS OFFICE.

Patient Signature: ____________________ **Date:** ____/____/____

Dr./Nurse's Notes____________________

____

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GONZALES CHIROPRACTIC

Informed Consent

I hereby consent and request the performance of acupuncture, chiropractic, medical services, physiotherapy and weight loss procedures, including adjustments, examination tests, diagnostic x-rays, physiotherapy, acupuncture, laser, massage, medical services, Chinese herbal medicine and nutritional supplements for the purpose of treatment, on me or for whom I am legally responsible, by the clinical staff at Gonzales Chiropractic.

I have been informed that acupuncture, chiropractic, medical services and physiotherapy are generally safe methods of treatment, but that, as with any health care procedure, there may be certain complications or side effects. Side effects include soreness, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, organ puncture, and burns. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) are traditionally considered safe, although possible side effects of taking the herbs include abdominal discomfort may occur. The clinic uses sterile disposable needles and maintains a clean and safe environment. I will notify a staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I have been told about the risks and benefits of acupuncture, chiropractic, medical services, physiotherapy, weight loss and other procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____ ________________
Printed Name of Patient, Parent or Guardian Date

____
Signature of Patient, Parent or Guardian

We have many success stories in our office and often patients wish to share these stories in an effort to help others. <u>Your picture, written testimonial or video will only be shared with your permission</u> and will only be available when YOU PROVIDE it to us. This is a standard publicity release in accordance with the Federal Trade Commission (FTC).

I hereby grant you, Gonzales Chiropractic all rights with this my irrevocable explicit approval to use my likeness, voice, etc., as captured or edited, recorded and rendered in various audio, visual, and written medium, to be used in commercial, instructional, and promotional activities as Gonzales Chiropractic sees fit. Gonzales Chiropractic shall own 100% rights, title and interest in resulting product.

____
Signature of Patient, Parent or Guardian

Massage Policy

We have a 24-hour cancellation policy. In the event that you must cancel or reschedule your massage, you must call 24-hours prior to your appointment time. If these terms are not met, a $30 fee will apply & charge to your credit card you provided.

Credit Card #___________________________________ EXP:__________________________

YOUR CREDIT CARD WILL BE CHARGED FOR $30.00 IF YOU ARE A NO SHOW!

We do accept and encourage tips for our massage therapist. These tips can be made via cash or credit card.

Note:

1-hour massages are roughly 50 mins long. 10 mins is used for you to get undressed/dressed.

1/2 -hour massages are roughly 20 mins long. 10 mins is used for you to get undressed/dressed.

Also, if you are late to your massage, it will run into your time.

For existing patients, regular cash rates apply.

These rates do not apply to Insurance/Workers Comp/Personal Injury cases.

$80 per 1-Hour Massage (if you buy a bulk of 10, you get 2 free)

$45 per 30- Minute Massage (if you buy a bulk of 10, you get 2 free)

Thanks

Signed____ Date______________________

CONSENT FOR CHIROPRACTIC TREATMENT OF A MINOR CHILD

I ____the Mother/Father/Legal guardian of ____ consent to the

Rendering of care, including diagnostic procedures, x-ray and treatment given by GONZALES CHIROPRACTIC. I acknowledge that I am responsible for all reasonable charges in connection eith care and treatment during visit.

I have read this form and certify that I understand its content

______________________________ ______________________

Patient's signature Date

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____________________________

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: ________________________________

____

Date of last menstrual period: ____________________

______________________________ ______________________

Patient's Signature Date