Dr. Lori Breiner, Whole-Body Chiropractic LLC

Welcome and thank you for selecting us to care for your health. We strive to provide you and your family and friends with the highest quality wellness care because you deserve the opportunity to reach your full potential in health and life. To help us meet all of your needs, please fill out all the forms provided completely. If you have any questions or need assistance, please ask us – we will be happy to help you.

NAME _____DATE _____

ADDRESS _____

CITY/STATE/ZIP _____

EMAIL _____ SOCIAL SECURITY # _____

SEX M F AGE _____ DATE OF BIRTH _____

RELATIONSHIP STATUS: _____ OCCUPATION _____

EMPLOYER/SCHOOL _____ EMPLOYER/SCHOOL PHONE _____

EMPLOYER/SCHOOL ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

SPOUSE'S SOCIAL SECURITY # _____ SPOUSE'S DATE OF BIRTH _____

SPOUSE'S PHONE NUMBER_____

CHILDREN NAMES AND AGES _____

WHO MAY WE THANK FOR REFERRING YOU? _____

PHONE NUMBERS

HOME PHONE _____ MOBILE PHONE _____

EMERGENCY CONTACT PERSON _____

EMERGENCY CONTACT HOME PHONE _____ MOBILE PHONE _____

PATIENT CONDITION & HEALTH HISTORY

1. WHAT BRINGS YOU HERE TODAY? _____
2. WHAT OTHER TREATMENTS HAVE YOU HAD FOR THIS CONDITION?

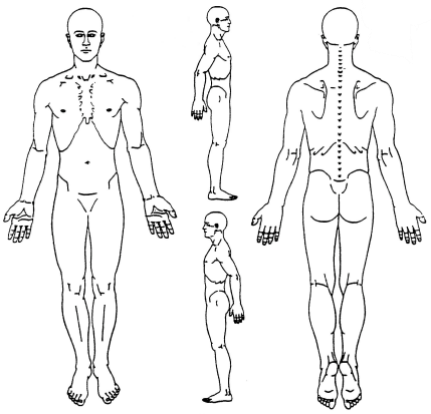
   ❑CHIROPRACTIC ❑NATUROPATHY ❑ORTHOPEDIC ❑NEUROLOGIST ❑PHYSICAL THERAPY ❑ MEDICATION ❑SURGERY
3. DATE OF LAST: PHYSICAL EXAM____ SPINAL X-RAY_____ MRI /CT SCAN _____ DENTAL EXAM _____
4. WHEN AND HOW DID THIS CONDITION BEGIN? ❑ IMMEDIATELY AFTER AN EVENT ❑MULTIPLE EVENTS ❑GRADUALLY DEVELOPED ❑NO REASON
5. HAS THIS CONDITION OCCURRED BEFORE? ❑YES ❑NO
6. IS THE PROBLEM GETTING WORSE? ❑YES ❑NO
7. IS THIS PROBLEM: ❑ CONSTANT ❑ COMES AND GOES ❑ ONLY WITH MOVEMENT
8. HOW DOES IT FEEL? ❑BURNING ❑SHARP ❑SHOOTING ❑DULL ❑ACHING ❑STIFFNESS ❑TINGLING ❑THROBBING ❑SWELLING ❑OTHER
9. RATE THE SEVERITY OF YOUR PAIN: (NO PAIN) 0 **1 2 3 4 5 6 7 8 9 10** (SEVERE PAIN)
10. WHAT MAKES YOUR CONDITION BETTER? _____WHAT MAKES YOUR CONDITION WORSE? _____
11. DOES IT INTERFERE WITH YOU'RE: ❑WORK ❑SLEEP ❑ DAILY ROUTINE ❑RECREATION
12. ACTIVITIES/MOVEMENTS THAT ARE DIFFICULT/PAINFUL TO PERFORM: ❑SITTING ❑STANDING ❑WALKING ❑BENDING ❑LYING DOWN ❑DRIVING ❑READING ❑GETTING UP
12. ANY OTHER ASSOCIATED SYMPTOMS? _____

PATIENT CONDITION & HEALTH HISTORY CONTINUED

13. PRIOR TESTS: ❑X-RAY, ❑MRI, ❑CT, ❑ULTRASOUND, ❑BLOOD TEST, ❑OTHER

14. PLEASE INDICATE YOUR DISCOMFORT ON THE DIAGRAM.

N=NUMBNESS, P=PINS AND NEEDLES, B=BURNING, A=ACHING, S=STABBING



15: DESCRIBE YOUR HEALTH NOW? ❑EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR

16. ARE YOU PREGNANT? DUE DATE?

17. WHAT ARE YOUR HEALTH GOALS?

_____

FAMILY HISTORY

PLEASE INDICATE IF YOU OR YOUR RELATIVES HAVE HAD ANY OF THE FOLLOWING:

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Heart trouble	Hypo-thyroidism	Kidney trouble	Nervous Breakdown	Ulcer	Stroke	Digestive issues
You													
Father													
Mother													
Brother													
Sister													
Spouse													
Children													
Grandparent													

1. CHILDHOOD DISEASES AND SYNDROMES
❑ALLERGIES ❑ASTHMA ❑ATOPIC ECZEMA ❑BRONCHITIS ❑CHICKEN POX ❑GERMAN MEASLES ❑MEASLES ❑MONONUCLEOSIS ❑MUMPS ❑RHEUMATIC FEVER ❑TONSILLITIS ❑WHOOPING COUGH (PERTUSSIS) ❑OTHER_____

2. PREVIOUS TRAUMA:
- ILLNESS/ SURGERIES/HOSPITALIZATIONS: _____
- INJURIES/FRACTURES/DISLOCATIONS: _____
- HAVE YOU EVER BEEN IN AN AUTOMOBILE OR OTHER SERIOUS ACCIDENTS? _____
- HAVE YOU EVER INJURED YOUR HEAD, SPINE OR BACK? _____

3. HAVE YOU EVER HAD DIAGNOSTIC STUDIES? ❑ NONE (CHECK ALL THAT APPLY)
❑ SPINAL X-RAY ❑ UPPER G.I. (STOMACH X-RAY) ❑ IVP (KIDNEY X-RAY ❑GALL BLADDER ❑ BARIUM ENEMA (COLON X-RAY) ❑ ELECTROCARDIOGRAM ❑ OTHER

4. WHICH IMMUNIZATIONS AND VACCINES HAVE YOU RECEIVED?
❑ MEASLES-MUMPS-RUBELLA ❑ POLIO ❑ TETANUS & DIPTHERIA ❑ CHICKEN POX ❑ PNEUMOVAX ❑ TETANUS BOOSTER ❑ DPT ❑ INFLUENZA ❑ HEPATITIS A/B SERIES

5. DO YOU HAVE DENTAL AMALGAMS (SILVER FILLINGS) OR ROOT CANALS? ❑ **NO** ❑ **YES**
DID YOU HAVE ANY AMALGAM FILLINGS REMOVED AND WHEN? _____

MEDICINES AND ALLERGIES

PLEASE LIST ALL MEDICATIONS, SUPPLEMENTS, AND VITAMINS, HERBAL/HOMEOPATHIC PRODUCTS THAT YOU ARE TAKING:_____
_____
_____

DO YOU HAVE ALLERGIES? ❑FOOD ❑ ANIMALS ❑ OUTSIDE ALLERGEN ❑ INSIDE ALLERGEN ❑ DRUGS ❑ OTHER

Patient name: _____ Date of Birth_____ Date_____

Mark (c) for current problems, check the box and indicate the age when you had any of the following.Also indicate 0 = Never or almost never have the symptom, 1 = Occasionally (effect is not severe) 2 = Occasionally (effect is severe) 3 = Frequently (effect is not severe) 4 = Frequently (effect is severe)

General
□ Allergies
□ Depression/Anxiety
□ Dizziness
□ Fainting
□ Fatigue
□ Fever
□ Headaches
□ Immune-compromised
□ Loss of sleep
□ Night sweats
□ Mental illness
□ Nervousness
□ Numbness/Tingling
□ Panic attack
□ Sick often
□ Swollen lymph glands
□ Tremors
□ Weight loss / gain
□ Diabetes

Muscle / Joint
□ Arthritis / rheumatism
□ Bursitis
□ Foot/knee/hip trouble
□ Hand/arm/shoulder pain
□ Muscle weakness
□ Low back pain
□ Neck pain
□ Mid back pain
□ Joint pain/swollen

Skin
□ Boils
□ Bruise easily
□ Dryness
□ Eczema/psoriasis
□ Hair loss
□ Hives or allergies
□ Itching
□ Pimples
□ Rash
□ Sensitive to chemicals
□ Varicose veins

Eye, Ear, Nose & Throat
□ Colds
□ Deafness
□ Difficultly swallowing
□ Ear ache
□ Eye pain
□ Gum trouble
□ Hoarseness
□ Nasal obstruction
□ Nose bleeds
□ Ringing of the ears
□ Sinus infection
□ Sore throat
□Vision problems
□ Tonsillitis/ swollen glands

Gastrointestinal
□ Abdominal pain
□ Bloody or tarry stool
□ Colitis / Crohn's
□ Colon trouble
□ Constipation
□ Diarrhea
□ Difficult digestion
□ Diverticulosis
□ Bloated abdomen
□ Excessive hunger
□ Gallbladder trouble
□ Hernia
□ Hemorrhoids
□ Intestinal worms
□ Jaundice
□ Liver trouble
□ Nausea
□ Painful defecation
□ Pain over stomach
□ Poor appetite
□ Vomiting
□ Vomiting of blood

Genitourinary
□ Bed-wetting
□ Bladder infection
□ Blood in urine
□ Kidney infection
□ Kidney stones
□ Prostate trouble
□ Pus in urine
□ Stress incontinence
Urination
□ Overnight more than twice
□ More than 8x in 24hrs
□ Decreased flow/force
□ Painful urination
□ Urgency to urinate □ Loss of bowel/bladder control

Cardiovascular
□ Blood thinners
□ High blood pressure
□ Low blood pressure
□ Hardening of the arteries
□ Irregular pulse
□ Chest pain
□ Palpitation
□ Poor circulation
□ Rapid or Slow heart beat
□ Swelling of ankles

Respiratory
□ Chest pain
□ Chronic cough
□ Difficulty breathing
□ Hay fever
□ Shortness of breath
□ Spitting up phlegm / blood
□ Wheezing

Women only
□ Congested breasts
□ Hot flashes
□ Lumps in breast
□ Menopause
□ Vaginal bleeding
□ Vaginal discharge

Menstrual flow
□ Reg. □ Irreg. □ Pain / cramps Days of flow: Length of cycle: Date - 1st day last period: Are you pregnant? □ yes, □ no If yes, how many months? How many children do you have? _ Birth control method: Date of last PAP test:
□ normal, □ abnormal
Date of last mammogram:
□ normal, □ abnormal □ Do you conduct self breast exams? □ Are you taking any hormone meds, Birth control pill, estrogens, thyroid?

Men Only
□ Breast lump
□ Difficult urination
□ Erectile problems
□ Sore on penis
□ Penis discharge
□ Lump on testicle

Endocrine (Hormonal)
□ Abnormal hunger/thirst
□ Crave salt/sweets
□ Cry easily
□ Depressed/Anxiety
□ Fatigue/ Overactive/ ADD
□ Gain/loss weight
□ Goiter/ Thyroid problems
□ Headache when stand up
□ Hot/cold intolerance
□ Hyper/Hypoglycemia
□ Loss of libido (sex drive)
□ Menstrual problems
□ Rapid heartbeat
□ Sleep problems
□ Stressed out

Check any of the conditions you have or have had: □ Alcoholism
□ Anemia
□ Anorexia/Bulimia
□ Appendicitis
□ Arteriosclerosis
□ Asthma
□ Autoimmune disease
□ Bronchitis
□ Cancer
□ Chemical dependency
□ Chicken pox
□ Cold sores
□ Cholesterol problems
□ Depression
□ Diabetes
□ Eczema
□ Edema
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Goiter
□ Gout
□ Hernia
□ Herniated Disc
□ Heart burn
□ Heart disease
□ Hepatitis
□ Herpes
□ High cholesterol
□ HIV/AIDS
□ Influenza
□ Malaria □ Measles
□ Migraines
□ Miscarriage
□ Mononucleosis
□ Multiple sclerosis
□ Mumps
□ Numbness/tingling
□ Pacemaker
□ Osteoporosis
□ Pneumonia
□ Polio
□ Psychiatric care
□ Rheumatic fever
□ Seizures
□ Strep/Staph infection
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Ulcers □ Is there anything else important?
_____

LIFESTYLE HABITS

1. EXERCISE: NONE MODERATE DAILY HEAVY
2. DESCRIBE YOUR ACTICITY IN THE DAY: SITTING STANDING LIGHT LABOR HEAVY LABOR
3. SMOKING/ TOBACCO USE: PACKS/DAY_____
4. ALCOHOL DRINKS/WEEK _____ 5. CAFFEINE CUPS/DAY _____
6. ARTIFICIAL SWEETENER PACKETS/DAY _____
7. SODA OR DIET DRINKS CUPS/DAY _____
8. HIGH STRESS REASON _____
9. FAST FOOD MEALS/WEEK _____

IS THERE ANYTING ELSE THAT YOU WOULD LIKE TO ADD TO THIS QUESTIONNAIRE: _____

CONSENT TO TREATMENT

I understand that Chiropractic and muscle testing is not a method for diagnosing or treating of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Chiropractic or muscle testing or any natural health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body's natural reflexes can be used as an aid to determine possible imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I understand that alternative methods of treatment are available. These have been described to me. I understand that there is no guarantee concerning the effectiveness of the treatment.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, stroke, disc injuries (although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment), dislocations, muscle/ligament strain, Homers' syndrome, diaphragmatic paralysis, pneumothorax, cervical myelopathy and costo-vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including neurological impairment. The possibility of such injuries resulting from cervical spine manipulation is extremely remote. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctors Office will prepare a superbill that I can submit to my health insurance. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time the services are provided.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments, screening and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I understand and agree to the terms and procedures set forth above. This permission form applies to subsequent visits and consultations. I hereby authorize the Doctor to treat my condition, as she deems appropriate through use of adjustments throughout my spine and extremities, applied kinesiology, acupuncture, myo-therapy, laser therapy and nutritional/herbal support.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____ _____

Printed name of Patient Signature of Patient Date

_____ _____

Signature of Patients' Representative (if minor or physically incapacitated) Date

_____ _____

Witness to Patients' Signature Date

_____ _____

Signature of Doctor Date