

## PERSONAL HISTORY

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Social Security# \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Driver's License Number \_\_\_\_\_

Employer / Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Check:  MARRIED  SINGLE  WIDOWED  DIVORCED  SEPARATED

Number of Children: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Internet Access  Yes  No Email Address: \_\_\_\_\_

Referred to This Office By: \_\_\_\_\_

## CURRENT HEALTH CONDITION

Purpose of This Appointment: \_\_\_\_\_

When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before?  Yes  NoHas The Condition  Worsened  Stayed The Same  Comes And Goes

How Bad Is The condition On A Scale Of 1-10, 10 Being The Worst \_\_\_\_\_

Does The Condition Interfere With  Sleep  Work  Daily ActivitiesIs Condition:  Job Related  Auto Related  Home Injury  Fall  Other \_\_\_\_\_

Date Of Accident: \_\_\_\_\_ Time Of Accident \_\_\_\_\_

Do most of your current & past health issues occur on one side of your body?  Right side  Left side  BothAre You, Or Do You Think You Are Pregnant?  Yes  No

Drugs You Now Take:

 Tranquilizers  Pain Killers/Muscle Relaxants  Blood Pressure Medication  Insulin  Antidepressants

Other \_\_\_\_\_

Do You Wear a Heel Lift in Your Shoe?  Yes  NoOther Doctors Seen For This Condition  Yes  No Who \_\_\_\_\_

Do You Suffer From Any Condition Other Than That For Which You Are Now Consulting Us? \_\_\_\_\_

## MEDICARE INFORMATION

Medicare # \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

## CURRENT HEALTH HABITS

Do You Smoke \_\_\_\_\_ Yes No

Do You Drink \_\_\_\_\_ Yes No

Do You Drink Bottled Water \_\_\_\_\_ Yes No

Do You Wear Your Seatbelt \_\_\_\_\_ Yes No

Do You Go To Your Dentist For Regular Check-Ups \_\_\_\_\_ Yes No

Do You Exercise Regularly \_\_\_\_\_ Yes No

Do You Belong To a Gym or Sports Club \_\_\_\_\_ Yes No

Sleeping Posture Side Stomach Back Restless

Rate Your Stress Level On a Scale Of 1 – 10 (10 being the worst) \_\_\_\_\_

## PAST HEALTH HISTORY

### Please Check or Describe:

Major Surgery/Operations: Appendix Tonsils Gall Bladder Hernia Back Surgery Broken Bones

Other \_\_\_\_\_

Major Accidents Or Falls: \_\_\_\_\_

Hospitalization (Other Than Above): \_\_\_\_\_

Previous Chiropractic Care: None Doctor's Name and Approximate Date of Last Visit: \_\_\_\_\_

### HEALTH PROBLEMS (Please check all that apply)

- Severe or Frequent Headaches
- Loss of Sleep
- Pain Between Shoulders
- Frequent Neck Pain
- Numbness or Pain in Arms / Legs
- Lower Back Problems
- Digestive Problems
- Ulcers / Colitis
- Heart Attack / Stroke

- Sinus Problems / Asthma
- Congenital Heart Defect
- Heart Murmur
- High / Low Blood Pressure
- Difficulty Breathing
- Arthritis
- Pinched Nerve(s)
- Diabetes
- ADD / ADHD / Autism

- Dizziness
- Shingles
- Hepatitis
- Cancer
- Anemia
- HIV / AIDS
- Tuberculosis
- Osteoporosis
- Thyroid High Low

# SUBSTANCE SURVEY FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Please list any **prescription** medications you are currently taking / have taken in the last year:

**MEDICATIONS**

**REASON**


Please list any **over-the-counter** medications you are currently taking / have taken in the last year:

**PRODUCT**

**SYMPTOM**

**QUANTITY &  
FREQUENCY**


Please list any **vitamins, supplements, herbs or homeopathic remedies** you are currently taking or have taken in the last year. (Use the other side if needed)

**PRODUCT**

**AMOUNT TAKEN DAILY**

**HOW LONG TAKEN**


Check the following items which apply to you and indicate the amount used:

- |                                                     |                                          |                                           |
|-----------------------------------------------------|------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Coffee _____               | <input type="checkbox"/> Antacids _____  | <input type="checkbox"/> Alcohol _____    |
| <input type="checkbox"/> Tea _____                  | <input type="checkbox"/> Laxatives _____ | <input type="checkbox"/> Cigarettes _____ |
| <input type="checkbox"/> Soft Drinks _____          | <input type="checkbox"/> Candy _____     | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Artificial Sweetener _____ | <input type="checkbox"/> Ice Cream _____ | <input type="checkbox"/> _____            |

How many desserts do you have in an average week? \_\_\_\_\_

# TERMS OF ACCEPTANCE

When a patient seeks chiropractic/Biocranial health care at Dr. Augustine's office and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic/Biocranial has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment / Correction:** An adjustment or correction is the specific application of forces to facilitate the body's correction of subluxation and support HEALING in the body. Our method of correction is by specific adjustments and / or Biocranial corrections.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of infirmity.

**Subluxation:** Nerve interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Furthermore, Dr. Augustine's approach to healing may also be to provide the tools necessary for the body which is whole food nutrition and / or herbs and specific dietary recommendations.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a spinal/neurologic examination, 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 the 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 and provide nutrients to support the body's ability to heal. Our only method is specific adjusting / corrections of subluxation and whole-food nutrition / herbs.

I, \_\_\_\_\_ have read and fully understand the above statements. (Print name)

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

\_\_\_\_\_ (Signature) (date) \_\_\_\_\_

## Consent to evaluate and adjust a minor child

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_

\_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

## Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_ (Signature) \_\_\_\_\_ (date)