Confidential Patient Record DATE I.D. NUMBER

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 name & 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 ❑No

Has 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 Activities?

Is 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 ❑Both

Are 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 ❑No

Other Doctors Seen for This Condition ❑Yes ❑No Who_____

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

_____

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	❑ Sinus Problems / Asthma	❑ Dizziness
❑ Loss of Sleep	❑ Congenital Heart Defect	❑ Shingles
❑ Pain Between Shoulders	❑ Heart Murmur	❑ Hepatitis
❑ Frequent Neck Pain	❑ High / Low Blood Pressure	❑ Cancer
❑ Numbness or Pain in Arms / Legs	❑ Difficulty Breathing	❑ Anemia
❑ Lower Back Problems	❑ Arthritis	❑ HIV / AIDS
❑ Digestive Problems	❑ Pinched Nerve(s)	❑ Tuberculosis
❑ Ulcers / Colitis	❑ Diabetes	❑ Osteoporosis
❑ Heart Attack / Stroke	❑ ADD / ADHD / Autism	❑ 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:

❒ Coffee _____ ❒ Antacids _____ ❒ Alcohol _____
❒ Tea _____ ❒ Laxatives _____ ❒ Cigarettes _____
❒ Soft Drinks _____ ❒ Candy _____ ❒ Other_____
❒ Artificial Sweetener _____ ❒ Ice Cream _____ ❒ _____

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 removal of nerve system interference and SUPPORT HEALING in the body. Our method of removal 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 nerve system interference. 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 nerve system interference and whole-food nutrition / herbs.

I, _____have read and fully understand the above statements. (Print name)

_____(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.

_____(Signature) (date) _____

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)