Rhinebeck Chiropractic Health History

Please fill out this form as completely and as accurately as possible.

Today's Date _____

PERSONAL DATA

Name_____ Age_____ Date of Birth _____

Parent's Names (if under 18) _____

Home Address_____ City_____ State____ Zip_____

Home Phone (_____)_____ Alternate Phone (_____)_____

Occupation _____ Employer _____

Email Address _____

SS# _____ Emergency Contact & Phone_____

Marital Status □ S □ M □ D □ W □ L/W Spouse/ Partner_____

Names and ages of children_____

Whom may we thank for referring you to our office? _____

Email _____

REASONS FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Rhinebeck Chiropractic can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work	Y	N	Driving	Y	N	Sleep	Y	N
School	Y	N	Walking	Y	N	Sitting	Y	N
Exercise	Y	N	Eating	Y	N	Love Life	Y	N

HEALTHCARE PRACTITIONER HISTORY

Have you ever received chiropractic care? □ Y □ N Name of D.C. _____

How long under care? □____Days □____Weeks □____Months □____Years

Date of last visit _____ Why did you stop? _____

Have you consulted or do you regularly consult any of the following providers?

(Check all that apply)

□ Medical Physician □ Naturopath □ Acupuncturist □ Homeopath

□ Massage Therapist □ Psychotherapist □ Energy Healer □ Dentist

Reason why:_____

_____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period:_____

If pregnant, Due Date: _____ Name of OBGYN or Midwife _____

Where will you be birthing your baby? □ Hospital □ Birthing Center □ Home

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the central nerve system. The vertebrae (bones of the spinal column) surround and protect the delicate nerve system. Chiropractors are specialists trained in "early detection" of injury to the spine & nerve system.

The information below will help us see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate how you were birthed. (If you do not know, skip to the next question)

□ Home □ Natural □ Hospital □ Cesarean section □ Forceps

□ Breech □ Cord around neck □ Prolonged labor □ Drug induced labor □ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had and accidents or injuries in your life related to the following? (Check all that apply)

□ Automobile □ Motorcycle □ Bicycle □ Sports □ Playground □ Abuse

If yes, state **type of injury and date:**_____

_____

Have you ever hurt/injured your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? □ Y □ N

If yes, list **body parts injured and date:**_____

_____

Have you ever broken, fractured or sprained any bones or joints? □ Y □ N

If yes, state **type of injury and date:**_____

Have you ever been hospitalized? □ Y □ N

If yes, state **reason and dates:** _____

_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	Y	N	Loss of a loved one	Y	N	Abuse	Y	N
Work or school	Y	N	Divorce/Separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following may reveal exposures you may have had.

Were you vaccinated? □ Y □ N If yes, did you have a reaction? □ Y □ N

Have you been exposed to any of the following on a regular basis, (past or present)?

□ Toxic chemicals □ Second hand smoke □ Drug therapy

□ Radiation □ Chemotherapy □ Other

If yes, please list: _____

_____

Do you have **allergies** to any foods? □ Y □ N

If yes, please list: _____

Do you consume any of the following presently?

□ Coffee/Caffeine □ Alcohol □ Tobacco □ Over the counter drugs □Prescribed drugs

Please list all medications you are currently taking (prescribed & over the counter):

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**? □ Good □ Fair □ Poor

How do you grade your **emotional/mental health**? □ Good □ Fair □ Poor

How do you rate your overall "**quality of life**?" □ Good □ Fair □ Poor

Do you **exercise** regularly? How often? _____

Do you take **supplements**? If yes, please list: _____

Do you follow a **special dietary regime**? If yes, what? _____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic care***: (Check all that apply)

□ Relief from a symptom or problem

□ Relief & prevention of a symptom or problem

□ Healthier spine & nerve system

□ Optimal health on all levels

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical stresses, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The chiropractic examination is specifically designed to detect Vertebral Subluxations in all phases of their progression.

FINANCIAL INFORMATION

Payment in full is expected on all **FIRST VISIT** services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment: □ Cash □ Check □ Credit Card

First Visit Fees: Comprehensive Examination: $150

Adjustment (If needed): $50

Total: $200

INSURANCE

In the spirit of keeping our fees low and to save time and office overhead, this office does not accept assignment from insurance companies. If you do have chiropractic benefits, we will furnish any and all documentation you may need for reimbursement. If you have an insurance card, please give it to the front desk, so they may make a copy.

PLEASE READ AND SIGN BELOW

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Joshua Burckhard and Dr. Jessica Burckhard permission to render care to me today. The initial visit includes a health history/consultation, chiropractic examination, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature_____ Today's Date_____

Signature of Parent (For Minor)_____ Today's Date_____

Thank you for choosing Rhinebeck Chiropractic.
We look forward to helping you.

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this office:

A. Chiropractic is a specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined by the "law of this jurisdiction" involves the application of specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is a part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by other providers.
F. Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly with the doctors on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

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

All questions regarding the doctor's objective pertaining to my care in this office have been

answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (Printed) Relationship to Patient

_____ _____

Patient or Legal Guardian Signature Date