



Patient Health History for Well-Adjusted Chiropractic

Today's Date ____/____/____ Referred by: _____

First Name _____ Last Name _____ Middle Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ (best way to contact you)

Home email _____

(By providing my email address, I authorize my doctor to contact me via the email address(es) provided.)

Signature of Patient _____ Social Security _____-____-_____

Date of Birth ____/____/____ Age _____ Gender (check one) Male Female

Preferred Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

Marital Status (check one) Single Married Partnered Widowed Divorced

Employment Status (check one)

Employed Student Other Retired Self Employed

If employed, what is your occupation: _____

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Vietnamese Italian Korean Russian Portuguese Japanese

Height: _____

Weight: _____

BP: ____/____ (If known)

List any Allergies:

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
- Rubber Seasonal Allergies Shellfish Soaps Wheat
- Medications (ALLERGIES) _____ Other: _____

List any Surgeries:

- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

List ALL Past Medical History Conditions:

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
- Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
- Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
- Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
- Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
- Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
- Stroke/Heart Attack Other: _____

List your Family History:

- Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition
- High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio
- Prostate Problems Stroke/Heart Attack Other: _____

Have you had any auto or other accidents? No Yes

Describe: _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10

No interest *Very Interested*

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

****List current medications, supplements, and/or herbs including frequency and dosage(if known) below.
(If there are no current medications leave blank.)**

Are you pregnant? Yes No Due Date: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe:

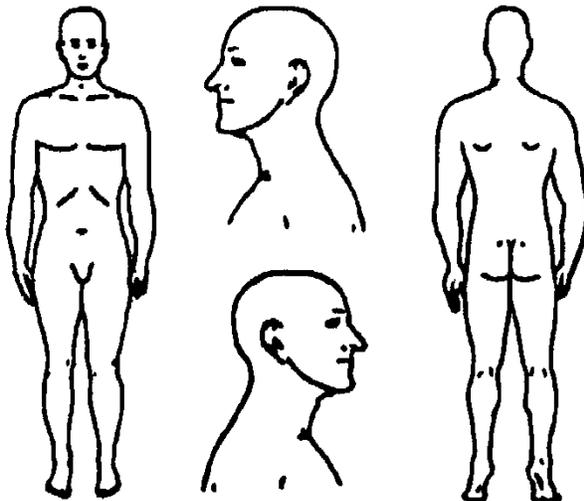
Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

**PLEASE MARK YOUR AREAS OF PAIN ON THE
DIAGRAM BELOW**



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
- Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain
 Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

- 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

- (0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

INFORMED CONSENT TO CHIROPRACTIC CARE

Well Adjusted Inc.
Dr. Jennifer S. Hensley
312 8th Avenue, West
Hendersonville, NC 28791
828-698-7888

Office Policies/ Informed Consent to Chiropractic Care:

We welcome you as a new patient to our office. We appreciate the confidence you have shown in us by consulting this office concerning your present health condition(s). We invite you to discuss with us any questions regarding our services.

Our policy requires payment in full rendered at time of visit, unless other arrangements have been made with our staff. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other fees, and expenses incurred in collecting your account.

Please be on time for your appointment. Our treatment methods require adequate time; coming late for appointments is not acceptable to the office and will not serve your health interests. If an emergency should arise, please phone the office and ask if you should come in for the visit or reschedule your appointment.

Our office requires 24 hours notice on all cancellations. In the case of any late cancellations or missed appointments there will be a \$25.00 charge. Patients that repeatedly miss appointments will be charged for the full amount of the scheduled treatment.

Our office has an answering machine in order for us to serve you efficiently. If the office is closed, please leave your name, telephone number (including area code), and your message on the machine. We will return your call as soon as possible.

Please read and sign below:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above. I have had the opportunity to discuss with the doctor and/ or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments. Alternative types of care have been reviewed. Though chiropractic adjustments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to adjustments. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains and bruises. I understand that chiropractic is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic adjustment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

I acknowledge that I have read the above office policies and informed consent:

Signature of Patient _____ Date _____

*Signature of Parent/Guardian _____ Date _____

****Please assure you have given the front desk your most up to date insurance card and driver's license.
Please be aware that payment is due BEFORE treatment. Thank you for your understanding!**

PRIVACY PRACTICES ACKNOWLEDGEMENT

Well-Adjusted, Inc
312 8th Avenue, West
Hendersonville, NC 28791

828-698-7888

ACKNOWLEDGEMENT FORM

- I have reviewed the posted Notice of Privacy Practices located in the office lobby below the front office window and agree to what is stated on it.

Name: _____

Birthdate: _____

Signature: _____

Date Signed: _____