TOTAL BODY CHIROPRACTIC & MASSAGE

PATIENT HISTORY FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____

Home Address: _____

Age: _____ Date of Birth: _____ Email: _____

Marital Status: S M P W D

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you? _____

PATIENT EMPLOYER / SCHOOL INFORMATION

□ Employed □ Retired □ Student □ Other

Employer: _____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting worse? _____

Rate the severity of your pain today on a scale of 1-10 (zero being no pain) _____

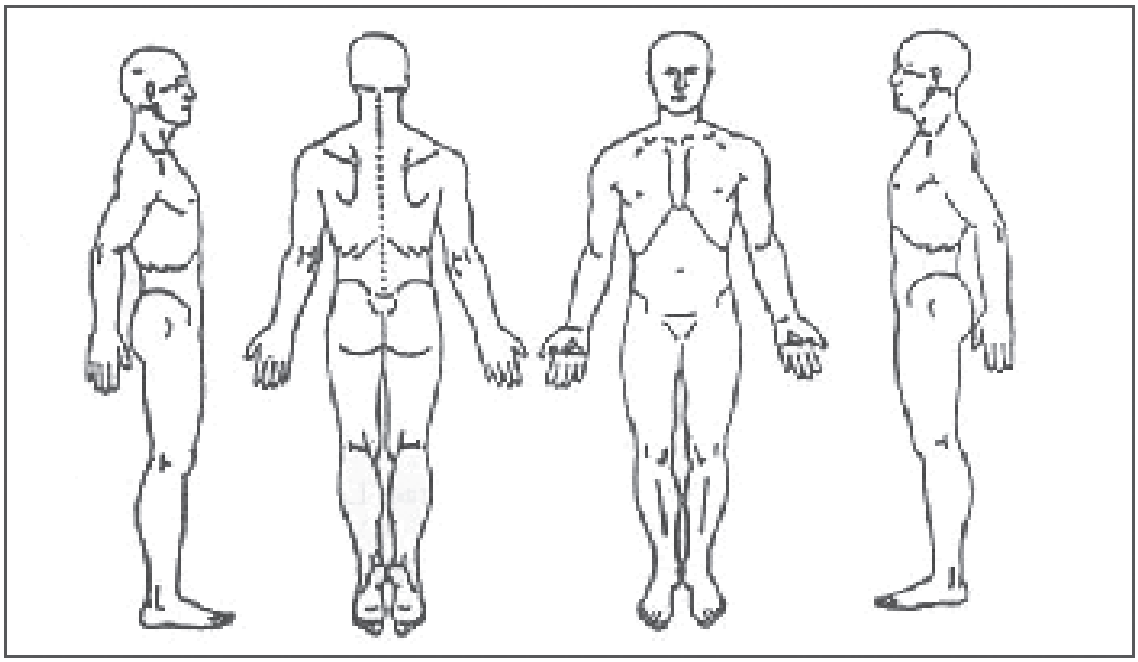
Rate the severity of your pain when you were first injured _____

What is the quality of your pain?

□ Sharp □ Dull □ Tingling □ Throbbing □ Numbness □ Aching □ Burning

□ Swelling □ Cramping □ Shooting □ Stiffness □ Other: _____

Please mark areas of pain below with an X.



HEALTH HISTORY

What treatment(s) have you already received for your condition and what was the outcome?

□ Medication(s) _____

□ Acupuncture _____

□ Physical Therapy _____

□ Surgery _____

□ Chiropractic _____

□ Other _____

Name and phone numbers of doctor(s) who have treated you for this condition.

_____

Date of last:

Physical Exam: _____ Spinal X-Ray: _____

Spinal Exam: _____ Blood Test: _____

Bone Density Test: _____ MRI/CT Scan: _____

Is this condition due to an accident? □ Yes □ No Date: _____

Type of Accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Worker's Comp □ Other

Mark a "C" next to current problems, and check and indicate age when you had any of the following.

GENERAL
- □ Allergies
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Headaches
- □ Loss of Sleep
- □ Mental Illness
- □ Anxiety
- □ Tremors
- □ Weight Loss / Gain
- □ Cancer

MUSCLE / JOINT
- □ Arthritis
- □ Bursitis
- □ Foot Trouble
- □ Muscle Weakness
- □ Low Back Pain
- □ Neck Pain
- □ Mid-Back Pain
- □ Other Joint Pain
- □ Gout
- □ Osteoporosis
- □ Autoimmune

SKIN
- □ Boils
- □ Bruise Easily
- □ Dryness
- □ Hives
- □ Allergies
- □ Itching
- □ Rash
- □ Varicose Veins
- □ Skin Cancer

CARDIOVASCULAR
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Pain in Chest
- □ Palpitations
- □ Swelling of Ankles
- □ High Cholesterol
- □ Diabetes
- □ Stroke / Heart Attack

RESPIRATORY
- □ Chest Pain
- □ Chronic Cough
- □ Difficulty Breathing
- □ Hay Fever
- □ Asthma
- □ Shortness of Breath
- □ Bronchitis
- □ Pneumonia
- □ Emphysema

GASTROINTESTINAL
- □ Abdominal Pain
- □ Bloody or Tarry Stool
- □ Colitis / Chron's
- □ Constipation
- □ Diarrhea
- □ Painful Defecation
- □ Bloating
- □ Diverticulosis
- □ Excessive Hunger
- □ Gallbladder Issues
- □ Hernia
- □ Hemorrhoids
- □ Intestinal Worms
- □ Jaundice
- □ Liver Trouble
- □ Nausea
- □ Stomach Pain / Ulcer
- □ Poor Appetite
- □ Vomiting

GENITOURINARY
- □ Bed-wetting
- □ Bladder Infection
- □ Blood in Urine
- □ Kidney Infection
- □ Kidney Stones
- □ Prostate Trouble
- □ Stress Incontinence
- □ Urgency to Urinate
- □ Painful Urination
- □ Decreased Flow

EYE, EAR, NOSE, and THROAT
- □ Colds
- □ Deafness
- □ Eye Pain
- □ Gum Trouble
- □ Ringing in the Ears
- □ Sinus Infections
- □ Sore Throat
- □ Vision Problems

WOMEN ONLY
- □ Breast Tenderness
- □ Hot Flashes
- □ Lumps in Breast
- □ Menopause
- □ Vaginal Discharge
- □ Irregular Cycles

Menstrual Flow
- □ Heavy □ Light
- □ Pain / Cramps

Days of Flow _____

Length of cycle from 1st day of bleeding to next cycle _____

Are you pregnant?
- □ Yes □ No

# of Pregnancies _____

# of Children _____

DOCTOR'S NOTES

PAST HEALTH HISTORY

Please explain any of the following that apply. Date

Hospitalizations: _____ _____

Head Injuries / Falls: _____ _____

Broken Bones / Dislocations: _____ _____

Surgeries: _____ _____

ACTIVITIES OF DAILY LIVING

Work Activity

□ Sitting
□ Standing
□ Computer Use
□ Phone Use
□ Ergonomic Evaluation?
□ Headset
□ Light Labor
□ Heavy Labor
□ How many hours per week do you work?_____

Habits

□ Alcohol: Drinks / Week _____
□ Smoking: Packs / Day _____
□ Coffee / Caffeine per day _____
□ Stress Level (0-10): _____
□ Exercise: Days / Week _____
□ Hours of Sleep: _____
□ Amount of Water / Day: _____
□ Amount of Sugar: _____
□ Soda / Day: _____

MEDICATIONS / SUPPLEMENTS REASON / CONDITION

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any other health issues or concerns we should be made aware of?

_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand that it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

□ Patient Signature □ Parent / Guardian (if under 18 years old) Date

TOTAL BODY CHIROPRACTIC & MASSAGE

SOFT TISSUE TREATMENT – INFORMED CONSENT

Your exam indicates that you may benefit from soft tissue treatment. Soft-tissue treatments are designed to break up and re-organize scar tissue (adhesions) from old injuries and encourage proper healing and minimize scarring for new ones. This allows for the return of normal tissue function to injured areas.

Accomplishing the goals of soft-tissue treatment can be achieved in different manners. Graston Technique® (GT) does this utilizing an instrument while Myofascial Release Technique (MRT) uses the hands. Often times, soft-tissue treatments are used in conjunction with chiropractic adjustments for the best results.

We believe soft-tissue treatment may be effective in your case; however, prior to initiating, we need to make sure the technique is right for you. Please answer the following questions. If you have any questions or concerns, please speak with your clinician.

Please check any of the following that apply to you to help us determine possible risk factors.

- ☐ Do you bruise easily?
- ☐ Are you taking blood thinners or anticoagulants?
- ☐ Do you take aspirin on a regular basis?
- ☐ Have you taken cortisone on a regular basis?
- ☐ Have you ever had inflamed veins or blood clots?
- ☐ Do you bleed for long periods of time after you cut yourself?
- ☐ Do you have surgical implants in your body?
- ☐ Do you currently have any infections?
- ☐ Do you have uncontrolled high blood pressure?
- ☐ Do you have any skin conditions?
- ☐ Do you have diabetes or kidney disease?
- ☐ Have you been diagnosed with gout, RA, or other inflammatory arthritis?

Common side effects and/or reactions to soft tissue treatment include local discomfort during the treatment, reddening of the skin, superficial tissue bruising, and post-treatment soreness.

I have read the previous information regarding risks and benefits of soft-tissue treatment and my clinician has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient Name _____ Date _____

Signature _____ Date _____

Doctor's Signature _____ Date _____

TOTAL BODY CHIROPRACTIC & MASSAGE

CONSENT TO TREATMENT

Total Body Chiropractic offers a natural and alternative health approach when addressing your health concerns. We do so without the use of drugs or surgery. If you feel you need drugs, surgery, or medical intervention, we encourage you to seek that type of care. If, at any time, we feel that medical intervention is necessary, we will refer you to a medical facility.

We do not attempt to diagnose, treat, or cure any diseases. Our goal is to assist your body's natural abilities to heal itself. This may be done through chiropractic care, Graston Technique™, MRT soft tissue therapy, herbal remedies, nutritional supplementation, and/or lifestyle changes.

We do everything possible to detect the underlying causes of your body's state of health. It is only through eliminating these underlying causes that optimal health can be achieved.

Regarding chiropractic care, certain risks must be disclosed. Complications include, but are not limited to fractures, disc injuries, dislocations, and muscle or ligament strains. There have been reported cases of injury to the vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death.

The possibility of such injuries resulting from cervical spine manipulation is extremely remote. Regarding laboratory testing, we respect patient confidentiality, and do not share your lab results with other practitioners unless requested to do so by you. However, at times it becomes necessary to consult and discuss your case with other doctors at the lab itself. This is in your best interest so that we may be fully prepared to help you achieve your health goals in any way that we can.

I consent to the treatment offered and/or recommended to me, including osseous and soft tissue manipulation. This consent applies to all my present and future care with Dr. Bari Liebowitz, DC.

By signing this form, I state that I have weighed the risks involved with undergoing treatment, and give my consent to care at Total Body Chiropractic with Dr. Bari Liebowitz, D.C.

Patient Name _____ Date _____

Patient Signature _____ Date _____

Parent / Guardian Signature _____ Date _____
(if under 18 years old)

TOTAL BODY CHIROPRACTIC & MASSAGE

PRIVACY PRACTICES – PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Alternative Care Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature _____ Date _____

Print Patient Name _____ Date _____

TOTAL BODY CHIROPRACTIC & MASSAGE

CHIROPRACTIC INSURANCE AGREEMENT

Your insurance benefits will cover most of your chiropractic costs, but please be aware that there are certain exceptions. Benefits often include a maximum number of visits per year, and may include a limited allowed dollar amount per year. The insurance companies do not guarantee payment for services rendered. By signing this form, you agree to pay your deductible (if applicable) and your co-pay at the time of service, as well as for any services not covered by your insurance company (such as supplements, holistic consultations, rejected claims, etc).

Patient Signature _____ Date _____

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CANCELLATION POLICY

A 24-hour notice is requested when cancelling or rescheduling your appointment so that we may offer that time to other patients. Missed appointments without notice will be charged in full. The fee for missed chiropractic appointments is $60. The fee for missed massage appointments is $70. If you have purchased a chiropractic or massage package, one visit will be deducted for a missed appointment. Thank you for understanding.

Patient Signature _____ Date _____