

# Welcome To



## New Practice Member Initial Interview

Welcome to Pearson Chiropractic. Your time here today is as important for you as it is for us. The information you fill in here is paramount to the Chiropractor reaching conclusions and directional decisions about your health, from the past to the present and into the future. If there is anything you're not sure of then please don't hesitate to ask one of our friendly practice team members.

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Gender:      Male    Female      Date of Birth: \_\_\_\_\_      Age: \_\_\_\_\_

Circle one of the following:    Single      Partner      Married      Divorce      Widowed

Mailing Address: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Phone: H: \_\_\_\_\_ Work: \_\_\_\_\_ Can we contact you at work? \_\_\_\_\_

Cell: \_\_\_\_\_ SS#: \_\_\_\_\_

Please indicate the best number to contact you (Circle):    Home    Work    Cell    Other: \_\_\_\_\_

### Current Health Story:

What brings you to *Pearson Chiropractic*? (Please be specific): \_\_\_\_\_

\_\_\_\_\_

When did this start? \_\_\_\_\_

What do you think you did to yourself? \_\_\_\_\_

\_\_\_\_\_

Have you experienced this before, if so please elaborate: \_\_\_\_\_

\_\_\_\_\_

How would you describe the intensity/sensation? Sharp Dull Burning Numbness Other: \_\_\_\_\_

Does this radiate to any part(s) of your body? \_\_\_\_\_

How often do you experience it? Constant Intermittent Occasionally Rarely

Does it vary during the day and if so how? \_\_\_\_\_

What activities/actions aggravate it? \_\_\_\_\_

What activities/actions lessen it? \_\_\_\_\_

Has it changed since you first noticed it and if so how? \_\_\_\_\_

Are you taking/applying any home remedies/medications for this? Yes No

If yes, what, how much and how often? \_\_\_\_\_

\_\_\_\_\_

How does it interfere with your life? \_\_\_\_\_

\_\_\_\_\_

What do you hope we can do for you? \_\_\_\_\_

\_\_\_\_\_

How long do you think that will take? \_\_\_\_\_

Why did you make the decision to come now? \_\_\_\_\_

\_\_\_\_\_

### Concurrent Health Story:

Have you seen anyone else for this concern (past or present)? Yes No If yes, who, when and how long? \_\_\_\_\_

Are you seeing other health provider/s for any other health reason? Yes No If yes, who, what for and how long? \_\_\_\_\_

Have you accepted any previous diagnosis for this health concern? Yes No If yes, describe? \_\_\_\_\_

Have you had x-rays or any other scans for this concern? Yes No If yes, what and when? \_\_\_\_\_

\_\_\_\_\_

### Work Story:

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Type of work (circle relevant): Sitting Computer Standing Driving Lifting Other: \_\_\_\_\_

Previous occupations: \_\_\_\_\_

Spouse's occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

### Family Story:

|                              |     |    |                               |     |    |
|------------------------------|-----|----|-------------------------------|-----|----|
| Do you have children?        | Yes | No | Do you plan to have children? | Yes | No |
| Number of Children and Ages: |     |    | Previous Chiropractic Care:   |     |    |
| Name: _____ Age _____        |     |    | Yes No Reason: _____          |     |    |
| Name: _____ Age _____        |     |    | Yes No Reason: _____          |     |    |
| Name: _____ Age _____        |     |    | Yes No Reason: _____          |     |    |
| Name: _____ Age _____        |     |    | Yes No Reason: _____          |     |    |

### Chiropractic Story:

Have you received chiropractic care in the past? Yes No Did you have x-rays? Yes No

If yes to care, from whom? \_\_\_\_\_

How regular was the care (Circle)? Weekly Bi-monthly Monthly Other: \_\_\_\_\_

How long did you receive care(Circle)? 0-3mths 6-12mths 1-2yrs 3-5yrs 5+yrs

Reason/s for stopping? \_\_\_\_\_

## Discovery Story:

How did you discover us? \_\_\_\_\_

If referred, who may we thank for referring you? \_\_\_\_\_

## Family Story:

Please list any significant health history of any family member and their relation to you (i.e. mother, father, sibling, grandparent): \_\_\_\_\_

## Early Childhood Story:

Often the causes of our health concerns began in our early years:

To the best of your knowledge circle any of the following relevant to you:

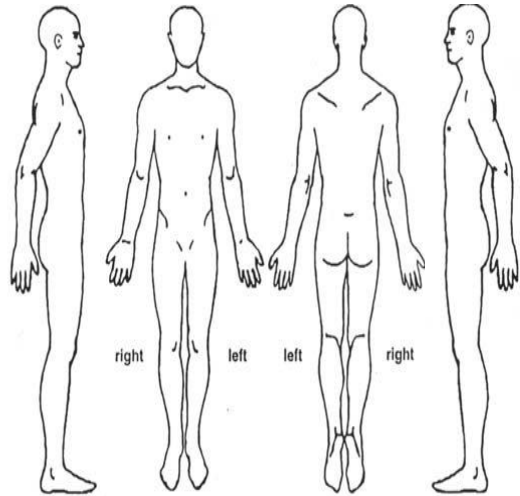
|                              |                    |                          |                        |
|------------------------------|--------------------|--------------------------|------------------------|
| Difficult pregnancy          | Long Birth         | Difficult Birth          | Forceps                |
| Caesarian                    | Breach             | Home Birth               | Hospital Birth         |
| Induced labor                | Drugs during birth | Post birth complications | Early Vaccinations     |
| Breast Fed (how long: _____) | Colicky Baby       | Congenital Concerns      | Chronic Ear Infections |
| Childhood asthma             | Childhood injuries | Major orthodontic work   | Learning Difficulties  |

## Systems Story:

Our physical and functional (systems and organs) health are related and rarely do concerns occur separate to other changes. This is because of the nerve system's extensive network and communication pathways. An organ under stress will have a corresponding area of the spine under stress. Therefore, please circle all concerns you have now or have had in the past (circle all that apply):

|                           |                             |                   |
|---------------------------|-----------------------------|-------------------|
| Back                      | Sciatica                    | Falls             |
| Chest                     | Shoulder/arm /hand          | Whiplash          |
| Neck                      | Hip/leg/foot                | Concussion        |
| Auditory /deafness        | Orthotics (past or current) | Sprain/Strain     |
| Eye/Face/Teeth/Jaw        | Arthritis                   | Toxic Chemicals   |
| Respiratory               | Heart attack/angina         | Smoker            |
| Asthma                    | Blood pressure              | Disrupted Sleep   |
| Frequent infections       | Easy bruising               | Eating Disorders  |
| Liver /Hepatitis          | Circulation                 | Major Illness     |
| Gall bladder              | Stroke                      | Vehicle Accidents |
| Colon/Stomach             | Cancer                      | Other: _____      |
| Glandular Fever           | Skin                        |                   |
| Kidney                    | Allergies/Sinusitis         |                   |
| Difficulty Urinating      | Sensitivities               |                   |
| Seizures/convulsions      | Mental                      |                   |
| Diabetes                  | Prostate (Men)              |                   |
| Thyroid                   | Menstrual (Women)           |                   |
| Stress                    | Pregnancy (Women)           |                   |
| Loss/Grief (Last 5 years) | Birth (Women)               |                   |
| Fractures                 | Surgery _____               |                   |

**Please mark your area(s) of concern**



right left left right

**On a scale of 1 to 10**

What is your current state of health?  
Poor 1 2 3 4 5 6 7 8 9 10 Optimal

What would you like your health to be?  
Poor 1 2 3 4 5 6 7 8 9 10 Optimal

Do you eat a diet of healthy and Organic foods (circle)?

Yes

No

Current exercise routine (describe): \_\_\_\_\_

Current or past (long term) medications or supplements (please list medication/supplement and for what reason): \_\_\_\_\_

**I CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

New Practice Member Name (please print): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

New Practice Member Signature: \_\_\_\_\_

Name and Signature of parent or legal guardian: \_\_\_\_\_ (If <18 years of age):

## Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT): \_\_\_\_\_