High Point Chiropractic Wellness
4856 W. Seneca Turnpike
Syracuse, NY 13215

Confidential Patient Case History

Name: ______________________________ Date: ____________

Address: ____________________ City: ______________ Postal Code: __________

Telephone: Home: ______________ Work:______________ Cell: ______________

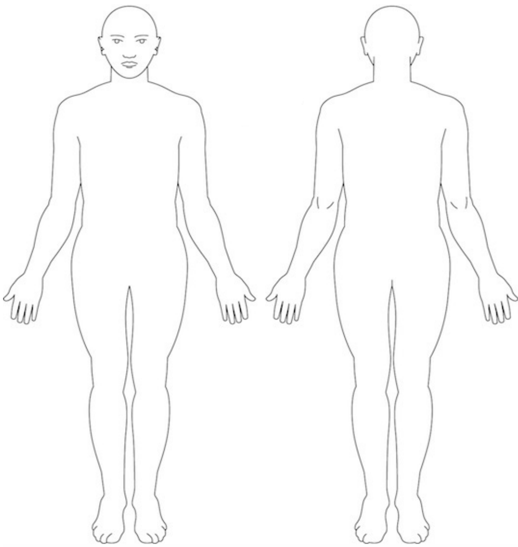
Messages may be left at (*check all that apply*): ❑ Home ❑ Work ❑ Cell Email: ____________________

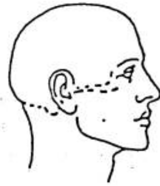
Age: _____ Birth date: ________ Marital Status: ❑ M ❑ S ❑ W ❑ D Occupation: ______________

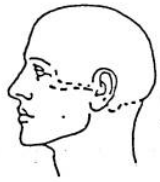
Spouse Name: ______________ # of Children: _____ Ages (*check any that apply*): ❑ 0-5 ❑ 6-12 ❑ 13-19 ❑ 20+

Whom may we thank for referring you? ______________________________

CURRENT COMPLAINT







Please use the following letters to indicate on the body diagram the TYPE and LOCATION of the symptoms you are currently experiencing:

A: Aching	T: Tingling
B: Burning	D: Dull
N: Numbness	S: Sharp
P: Pinching	O: Other

Please rate your pain on the following scale:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Intense Pain)

Please describe your current complaint(s): ______________________________

____

Date of injury/Onset of symptoms:____________ ❑ Unknown Have you had these symptoms before? ❑ YES ❑ NO

If YES, When: ______________ Have you seen any other practitioners for ***this*** injury/condition? ❑ YES ❑ NO

If YES, Who: ______________ When: ____________ Diagnosis: ______________

Have you had any testing/imaging? ❑ YES ❑ NO If YES, Test/Imaging: ______________ When: __________

Is your condition: ❑ Getting Better ❑ Getting Worse ❑ Staying the Same Are your symptoms: ❑ Constant ❑ Intermittent

Are you currently under the care of any health care practitioner for any other conditions? ❑ YES ❑ NO

Who is your Primary Care Physician? ______________ OB/GYN: ______________

Please list any specialists (*i.e. cardiologist, oncologist*) who you are currently under the care of: ______________

____

If applicable, who is your family's pediatrician: ______________________________

MEDICAL CONDITIONS

Have you been diagnosed with any of the following conditions:

❑ Arthritis ❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol ❑ Cancer (*type*): __________ ❑ Anxiety

❑ Depression ❑ Other (*please describe*): ______________________________

SURGICAL HISTORY

Have you ever had any of the following procedures:

❑ Mastectomy ❑ Prostate Surgery ❑ Biopsy ❑ Cancer Related Surgery ❑ Abdominal Surgery ❑ Moles Removed

❑ Laminectomy ❑ Cervical Spine Procedure ❑ Discectomy ❑ Joint Replacement ❑ Hysterectomy ❑ Cardiovascular Surgery

❑ Other (*please describe*): ____

ALLERGIES

Are you allergic to any of the following:

❑ Medications ❑ Dust/Mold/Pollen ❑ Pet Dander ❑ Wheat ❑ Soy ❑ Milk/Lactose ❑ Peanuts ❑ Eggs ❑ Fish/Shellfish

SOCIAL HISTORY

Alcohol: ❑ Never ❑ Occasionally ❑ Moderately ❑ Frequently **Manual Labor**: ❑ None ❑ Light ❑ Moderate ❑ Heavy

Caffeine: ❑ Never ❑ Occasionally ❑ Moderately ❑ Frequently **Computer Use**: ❑ Never ❑ < 2 hr/day ❑ 3-6 hr/day ❑ 6+ hr/day

Exercise: ❑ Never ❑ Occasionally ❑ Moderately ❑ Frequently **Smoking**: ❑ Never ❑ Occasionally ❑ Moderately ❑ Frequently

Fast Food: ❑ Never ❑ Occasionally ❑ Moderately ❑ Frequently **Chew Tobacco**: ❑ Never ❑ Occasional ❑ Moderate ❑ Frequent

FAMILY HISTORY

M: Mother **F**: Father **S**: Sibling **PGP**: Paternal Grandparent **MGP**: Maternal Grandparent

Arthritis: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP **Stroke**: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP

Cancer: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP **High Blood Pressure**: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP

Diabetes: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP **High Cholesterol**: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP

Thyroid: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP **Anxiety/Depression**: ❑ M ❑ F ❑ S ❑ PGP ❑ MGP

Other: ______________________________

SUBSTANCE ABUSE

Do you now, or have you ever, had abuse issues with any of the following substances:

Alcohol: ❑ Past ❑ Present **Cocaine**: ❑ Past ❑ Present **Methamphetamine**: ❑ Past ❑ Present **Marijuana**: ❑ Past ❑ Present

Other: ______________________________

PHYSICAL TRAUMA

Was your birth: ❑ Natural ❑ Drug Induced ❑ Forceps/Suction ❑ C-Section

Have you ever experienced: ❑ Concussion ❑ Slip/Fall ❑ Broken Bones ❑ Sports/Dance Injury ❑ Other ________________

Have you ever had an automobile accident: ❑ YES ❑ NO If YES, when: ❑ past year ❑ 1-5 years ago ❑ 5+ years ago

Please describe the accident: ____

RECREATIONAL ACTIVITIES

Check all that apply:

❑ Hiking ❑ Biking ❑ Dance ❑ Running/Walking ❑ Swimming ❑ Softball/Baseball ❑ Golf ❑ Basketball ❑ Skiing ❑ Soccer

❑ Tennis ❑ Weight Lifting

OCCUPATION

Which best describe your occupation (*check any/all that apply*):

❑ Police ❑ Fire/Rescue ❑ Military ❑ Homemaker ❑ Construction ❑ Healthcare ❑ Teacher ❑ Business Owner ❑ Daycare/ Child Care ❑ Truck Driver ❑ Clerical/Secretarial ❑ Executive/Legal ❑ Professional Services ❑ Food Service ❑ Retail

❑ Heavy Equipment Operator

REVIEW OF SYSTEMS

Please check the box of all conditions you presently have or have had in the past:

Musculoskeletal	Past	Present
Headache	❑	❑
Migraine	❑	❑
TMJ/Jaw Pain	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Elbow Pain	❑	❑
Wrist/Hand Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Knee Pain	❑	❑
Ankle/Foot Pain	❑	❑
Arthritis	❑	❑
Bursitis	❑	❑
Bulging Disc	❑	❑
Herniated Disc	❑	❑
Osteoporosis	❑	❑
Gout	❑	❑
Bone Cancer	❑	❑
Muscle Weakness	❑	❑
OTHER: ____________________		

Respiratory	Past	Present
Asthma	❑	❑
Wheezing	❑	❑
Chronic Cough	❑	❑
Pneumonia/TB	❑	❑
Emphysema	❑	❑
Lung Cancer	❑	❑
Difficult Breathing	❑	❑
Spit up Blood/Phlegm	❑	❑
OTHER: ____________________		

Blood/Lymph	Past	Present
Easy Bruising	❑	❑
Clotting Disorder	❑	❑
Varicose Veins	❑	❑
Leukemia	❑	❑
Lymphoma	❑	❑
OTHER: ____________________		

Endocrine	Past	Present
Hyperthyroid	❑	❑
Hypothyroid	❑	❑
Hair Loss	❑	❑
Parathyroid	❑	❑
Diabetes	❑	❑
Pituitary Problems	❑	❑
Cushing's Syndrome	❑	❑
Addison's Disease	❑	❑
OTHER: ____________________		

Constitutional	Past	Present
Fatigue	❑	❑
Poor Appetite	❑	❑
Weight Loss/Gain	❑	❑
Night Sweats	❑	❑
Difficulty Sleeping	❑	❑
OTHER: ____________________		

Gastrointestinal	Past	Present
Nausea	❑	❑
Vomiting	❑	❑
Ulcers	❑	❑
Reflux Disease	❑	❑
Appendicitis	❑	❑
Hernia	❑	❑
Pancreatitis	❑	❑
Hepatitis	❑	❑
Gall Bladder Problems	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Irritable Bowel	❑	❑
Ulcerative Colitis	❑	❑
Bloody/Black Stool	❑	❑
Colon Cancer	❑	❑
OTHER: ____________________		

Genitourinary	Past	Present
Flank Pain	❑	❑
Kidney Stones	❑	❑
Kidney Disease	❑	❑
Frequent Urination	❑	❑
Painful Urination	❑	❑
Incontinence	❑	❑
Blood in Urine	❑	❑
Prostate Cancer	❑	❑
Bladder Cancer	❑	❑
OTHER: ____________________		

Allergic/Immune	Past	Present
Cold/Flu	❑	❑
Seasonal Allergies	❑	❑
Autoimmune Disease	❑	❑
Corticosteroid Use	❑	❑
Hepatitis	❑	❑
STD	❑	❑
HIV/AIDS	❑	❑
OTHER: ____________________		

Neurologic	Past	Present
Numbness/Tingling	❑	❑
Carpal Tunnel	❑	❑
Sciatica	❑	❑
Vertigo	❑	❑
Concussion	❑	❑
Seizures	❑	❑
Brain Aneurysm	❑	❑
Brain Cancer	❑	❑
Parkinson's	❑	❑
Alzheimer's	❑	❑
OTHER: ____________________		

Emotional	Past	Present
High Stress	❑	❑
Nervousness	❑	❑
Anxiety	❑	❑
Depression	❑	❑
OTHER: ____________________		

Eyes/Ears/Nose/Throat	Past	Present
Blurred Vision	❑	❑
Double Vision	❑	❑
Glaucoma	❑	❑
Hearing Loss	❑	❑
Dizziness	❑	❑
Ear Infection	❑	❑
Ringing in Ears	❑	❑
Sinus Headaches/Infections	❑	❑
Deviated Septum	❑	❑
Tonsillitis	❑	❑
Painful Swallowing	❑	❑
OTHER: ____________________		

Cardiovascular	Past	Present
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Heart Disease	❑	❑
Vascular Disease	❑	❑
High Cholesterol	❑	❑
Poor Circulation	❑	❑
Heart Attack	❑	❑
Chest Pain	❑	❑
Jaw Pain	❑	❑
Arm Pain	❑	❑
Swelling of Legs	❑	❑
Pacemaker	❑	❑
Stroke	❑	❑
Aneurysm		
OTHER: ____________________		

Skin	Past	Present
Hives	❑	❑
Itching	❑	❑
Rashes	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Shingles	❑	❑
Mole Changes	❑	❑
Skin Cancer	❑	❑
OTHER: ____________________		

For Women Only	Past	Present
Breast Lump	❑	❑
Breast Tenderness	❑	❑
Breast Cancer	❑	❑
Heavy/Irregular Cycle	❑	❑
Painful Menses	❑	❑
Hot Flashes	❑	❑
Menopause	❑	❑
Yeast Infections	❑	❑
Pelvic Pain	❑	❑
Miscarriage	❑	❑
Endometriosis	❑	❑
Fibroids	❑	❑
Ovarian Cancer	❑	❑
Cervical Cancer	❑	❑
OTHER: ____________________		

Are you pregnant? ❑ Y ❑ N Weeks:________

VITAMINS AND MEDICATIONS

CURRENTLY TAKING	THIS IS FOR	BEGAN TAKING (MONTH/YEAR)
1		
2.		
3.		
4.		
5.		
6.		
7.		

CHIROPRACTIC CARE

What has been your experience with Chiropractic care in the past (*check all that apply*):
❑ none ❑ as a child ❑ in the past (*within 5 years*) ❑ in the past (*5+ years ago*) ❑ regular treatments ❑ intermittent treatments
❑ family members treated ❑ your children treated
Which chiropractor(s) have you seen in the past? ____

GOALS FOR CARE

People see Chiropractors for a variety of reasons. Some go for pain relief, some to correct the cause of the pain and others in order to have optimal health and function within the body with wellness. Please check the type of care that you desire so that we may be guided by your wishes whenever possible.

❑ **Relief Care** - Symptomatic relief of pain or discomfort.

❑ **Corrective Care** - Correcting and relieving the cause of the problem as well as the symptoms.

❑ **Wellness/Comprehensive Care** - Bring what may be malfunctioning within the body to the highest state of health and wellness.

HEALTH PROFILE

At High Point Chiropractic Wellness, we believe in restoring health to the mind, body and spirit. To better understand your specific needs, please give us some information about your goals for health:

1. ____
2. ____
3. ____

Please think about your current state of health for the following:

On a scale of 0-10, with 10 being the **best**, please rate your overall health right now: _____

On that same scale, please rate your current diet: _____

On a scale of 0-10, with 10 being the **most** stress, please rate your current stress level ______

INFORMED CONSENT

Please read this consent form, discuss it with the Doctor if you would like and sign where indicated at the bottom:

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy and medicine. Chiropractic seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize it's innate recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services. A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from (latent pathological defects, illnesses or deformities) which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime. A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). Vertebral subluxations are biomechanical interferences to the normal flow of electrical impulses along nerve pathways, caused by decreased motion of spinal bones (vertebrae). Chiropractic manipulations are performed in order to correct vertebral subluxations, thereby allowing the innate healing abilities of the body to work at a greater efficiency. When the subluxation has been corrected and the nerve supply is improved by chiropractic adjustments, the body can begin the process of repair that leads to better health. In some patients this happens quickly, in others, more slowly. In some patients, the repair and maintenance is complete, in others, it is partial. Due to the complexities of the body, no doctor can promise you specific results. This depends on the inherent recuperative powers of the body. Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition.. Your doctor of chiropractic may express an opinion as to whether or not you take this step, but ultimately you are responsible for the final decision. In the practice of chiropractic there are some risks to exam and treatment including, but not limited to fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement from symptoms or pain. The possibility of such injuries resulting from spinal adjustments is extremely remote. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, pain in the arms, legs, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms. By signing below, I understand that, although extremely rare, there may be complications. I do not expect the doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor to exercise judgement during the course of my treatments which they feel at the time, based upon the facts then known, is in my best interests. I understand that no guarantees or assurances have been made to me for a specific cure or result. I understand that at any time I can request further explanation regarding risks and benefits of care in this office, alternative courses of care and the consequences of not having the proposed treatment. I have read, or had read to me, the above consent. I have also had the opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan for myself. I intend this consent form to cover the entire course of treatment for myself and for any future conditions for which I seek treatment.

____________________________________ __________ ____________________ __________

Patient/Guardian Signature Date Doctor's Signature Date

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the Doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, lab procedures, chiropractic care or any clinic services that she deems necessary in my case. I further authorize him/her to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

______________________________ ____________ _____________________

Name **Date** **Signature**