THE LINDNER CHIROPRACTIC, MASSAGE & NUTRITION CENTER

Welcome to our office! Please take whatever time needed to give us the following details about you, your life, and your health. If you do not understand any of these questions, please feel free to ask.

Your Personal Information

Name:_____Today's Date:_____

Age:_____ ☐ Male ☐ Female DOB:_____ SS#:_____ - ____ - _____

Address:_____City:_____

State:____ Zip:_____ Your E-mail: _____@_____

Cell Ph:_(_____)_____ Msg Text OK? Y / N Home Ph: (____)_____

Employer:_____ Work you Perform: _____

Spouse / Partner:_____ Work Phone:(____)_____

In Case Of Emergency Notify: _____ Ph:(____)_____

Family Dr: _____ Type of Dr:_____ Ph:(____)_____

Who Should We Thank For Telling You About Our Office?_____

Your Current Health Concern

Primary Reason for Today's Visit: _____

Check the Severity of Your Complaint: (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe)

When Did This Begin?_____ Experienced Previously? ☐ Yes ☐ Never

Is This Condition: ☐ Job Related ☐ Auto Accident ☐ Fall or Injury ☐ Other:_____

Other Doctors Seen For This Problem:_____

Other Doctor's Opinions or Diagnosis: _____

Other or Secondary Health Concerns:_____

Drugs or Medications Now Taking: ☐ Pain Killers / Muscle Relaxants ☐ Tranquilizers

☐ Blood Pressure Medicine ☐ Antibiotics

☐ Other:_____

Your Past Health History

Previous Surgeries: ☐ Eyes / Ears / Nose / Throat ☐ Head/Neck ☐ Back /Spine

☐ Chest / Heart / Lungs ☐Abdominal ☐ Other:_____

Previous Fractures or Broken Bones: ☐ Yes ☐ No Describe:_____

Previous Falls or Accidents: ☐ Yes ☐ No Describe:_____

Previous Hospitalization: ☐ Yes ☐ No Describe:_____

Previous Chiropractic Care: ☐ Yes ☐ No Describe:_____

Similar Problem In Family: ☐ Yes ☐ No Describe:_____

Similar Problems With Co-Workers: ☐ Yes ☐ No Describe:_____

Do You Workout or Exercise? ☐ Yes ☐ No Describe:_____

NEW PATIENT INFORMATION

Check Any of the Following That May Apply To You

Health Issues:

☐ Polio	☐ Arthritis	☐ Heart	☐ Sleep Disorders
☐ Cancer	☐ AIDS or ARC	☐ Allergies	☐ Chronic Fatigue
☐ Diabetes	☐ Frequent Illnesses	☐ Epilepsy	☐ Genetic Disorders
☐ High Stress	☐ Poor Diet	☐ Nervousness	☐ Over Weight
☐ Under Weight	☐ Lungs	☐ Bones	☐ Kidney Disorders
☐ Endocrine	☐ Infections	☐ Other_____	

If Female, is there <u>any</u> possibility that you are pregnant? ☐Yes ☐ No

Intake Or Use:

☐ Alcohol	☐ Tobacco	☐ Pain Relievers	☐ Caffiene
☐ Sleeping Pills	☐ Birth Control Pills		☐Other:_____

Muscles-Skeleton	Circulation-Breathing	Eye-Ear-Nose-Throat
☐ Low Back Pain	☐ Chest Pain	☐ Eyes / Vision
☐ Middle Back	☐ Lungs/Breathing	☐ Dental / TMJ
☐ Neck	☐ Blood Pressure	☐ Throat / Voice
☐ Hips / Legs	☐ Heart Rate	☐ Ears / Hearing
☐ Joint Pain	☐ Poor Circulation	☐ Sinus Pain / Drainage
☐ Shoulders/Arms	☐ Coughing or Wheezing	

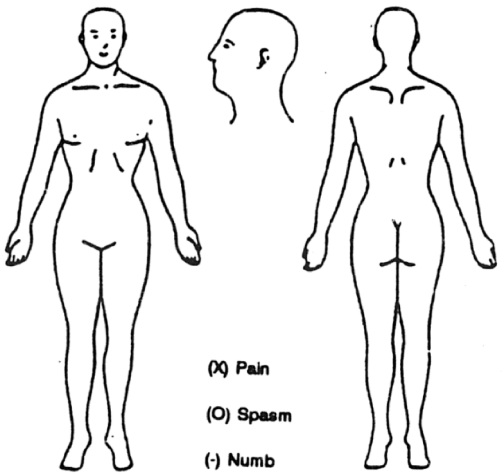
Check Any Problems That You May Have Had Within the Last Six Months

Nerve System	Digestion-Elimination	Urinary-Genitals
☐ Headaches	☐ Poor Appetite	☐ Pain With Urination
☐ Nervousness	☐ Excessive Thirst	☐ Infrequent Urination
☐ Numbness	☐ Nausea	☐ Frequent Urination
☐ Weak Muscles	☐ Diarrhea	☐ Weak Stream
☐ Dizziness	☐ Constipation	☐ Bladder Control
☐ Forgetfulnes	☐ Hemorrhoids	☐ Genitals
☐ Depression	☐ Weight Loss / Gain	
☐ Fainting	☐ Heartburn	
☐ Seizures	☐ Change In Stools	
☐ Cold Hands / Feet		
☐ Stress Reactions		
☐ Shaking / Tremors		

Female Only

☐ Menstrual Problems	☐ Breast Lumps/Pain
☐ Back Pain w/ Period	☐ Breast Implants

Please Mark Area Of Concern



I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge

Patient's Signature:

_____

Informed Patient Consent
And The Doctor-Patient Relationship

Chiropractic Care

It is the premise of Chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis. A state of normal homeostasis allows the body to establish normal function, express appropriate adaptation, and employ its recuperative, health sustaining powers. The relationship between the spine and the nervous system may affect the conduction of the nerve impulses over the nervous system affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment thus allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes and the physical and spinal conditions of each individual patient.

Chiropractic Analysis

The doctor will conduct a clinical analysis for the express purpose of determining the presence of the vertebral subluxation and the effects of the vertebral subluxation complex. If such is not detected, the patient will be informed and an attempt to refer the patient to an appropriate health care provider will be made.

Clinical Results

The purpose of chiropractic care is to promote health though the correction of the vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule, degree of response, or the efficacy of the chiropractic adjustment for any given patient. However, the doctor may make recommendations for clinical management based upon known circumstances and clinical experience.

Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic is licensed to provide a specialized unique, non-duplicating health service. The Chiropractor is licensed in a special area of practice and is available to work with other providers in your health care regimen.

Medical Diagnosis

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine and its effects on the nervous system, they are not internal medical or surgical specialists. Therefore, every patient should be mindful of their own symptoms and should secure other opinions should they have any concerns as to the nature of any other symptoms or their total health picture. Your Doctor of Chiropractic may express an opinion as to whether or not further consultation is necessary, but the patient is responsible for the final decision and any subsequent action.

Contra-indications To Chiropractic Care

Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures and disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contra-indicated. It is the responsibility of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of this doctor. By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for them in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures.

Patient Consent For Care

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing. I hereby request and authorize the doctor to render chiropractic care to me:

_____ _____

Signature of Patient, Parent, or Guardian *Date*

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ −

PAP ❑ + ❑ −

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

- ❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk

_____

- ❑ Weight lift - #days/wk_____
- ❑ Stretch - #days/wk_____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle