Welcome To Our Office

Confidential Patient Information Name: ________________________ Date: ________ Age: _____

Address: ______________________________ City: ______________ State: _______ Zip: _________
Cell Phone: ________________ Home Phone: ____________ Email: ____________________
Birth Date: ______________ Sex: M / F Marital Status: S / M / W / D Referred By: ________________
Occupation: __________________________ Employer: ________________________________
Spouse's Name: _________________ Spouse's Phone: _______________ Number of Children: _________
Emergency Contact: __________________________________ Contact Phone: ________________

Date of Last Physical Exam: ____________ With Whom:______________ Where: ________________
Reported Findings: ____
Surgeries, Hospitalizations, Serious Illnesses (list year in brackets): ______________________________
____
____
Fractures, Dislocations, Major Dental Work (list year in brackets): ______________________________
____
Medications / Drugs You Are Taking (state reason in brackets following drug):
____
____

Conditions You Have Had: (put an X)

__Allergies
__Alcoholism
__Anemia
__Arthritis / Joint Pain
__Asthma
__Back Pain
__Breathing Problems
__Cancer
__Depression
__Diabetes
__Digestive Disorders
__Dizziness
__Epilepsy
__Fatigue
__Headaches
__Heart Trouble
__High Blood Pressure
__Hypoglycemia
__Neck Pain
__Neuritis
__Nervousness
__Numbness
__Parasites
__Poor Appetite
__Poor Circulation
__Prostate Problems
__Rheumatic Fever
__Sinus Troubles
__Stroke
__Tuberculosis
__Ulcer
__Urinary Trouble
__Venereal Disease
__Weight Loss
__Yeast / Candida
____

Primary Health Concerns:

List Your Health Concerns According To Severity	Rate Of Severity 1= Minimal 10= Unbearable	When Did It Begin?	Have You Ever Had This Before?	% Of Day That Symptoms Are Present?	Better? Worse? Same?
1)					
2)					
3)					
4)					
5)					

Other Doctors Seen For These Conditions: ____
Have You Been Treated For Any Other Condition In The Past Year? Y / N (if so, describe):
____
Health Goals (what are your health goals for the next 6-12 months?): ______________________________
____

Height: ______ Weight (now) ______ (One Yr. Ago) _____ (Adult Max) ______ Age ____ (Adult Min) ______ Age ____
Known Allergies: ____

____

Habits:

Do You Smoke? Y / N What? _____________ How Many / Day ______ Since When? ________
Other Tobacco Products? Y / N What? _____________ How Many / Day _______ Since When? ________
Drink Coffee? Y / N Cups / Day ________ Drink Caffeinated Tea? Y / N Cups / Day ______
Colas / Soft Drinks? Y / N Avg. # / Day ______ Glasses Water / Day ___________
Alcoholic Beverages? Y / N Avg. # / Wk ________ Mostly What? _________________________
Do You Eat Red Meat/? Y / N Are You A Vegetarian? Y / N If So, For How Long? _________________
Are You Dieting? Y / N If So, Describe ____
Do You Eat Fast Food? Y / N If So, How Many Times / Week ___________________________________
List Nutritional Supplements You Take: ____

____

Bowel Movement Frequency: ______________ Difficulty? Y / N Approximate # of Times Urinate / Day _________
Do You Sleep Well? Y / N If No, Describe ____________________________ Avg. Hours / Night ________
Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe _____________________________

Exercise:

Do You Exercise? Y / N Describe ____
Are You In Training For A Particular Sport? Y / N Describe ______________________________________

Women Only: Menstrual History

Age at Onset: _____ Are Your Periods Regular? Y / N Cycle: ____ days (start to finish) Use Birth Control Pill? Y / N
Your Flow Is: Heavy Medium Light Date Of Last Period: ______ Cramping? Y / N PMS? Y / N

Family History: (Place an X in the appropriate boxes)

	Living?	Age / Age At Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Grandparents													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandparents													
Mother's Siblings													
Your Siblings													
Your Children													

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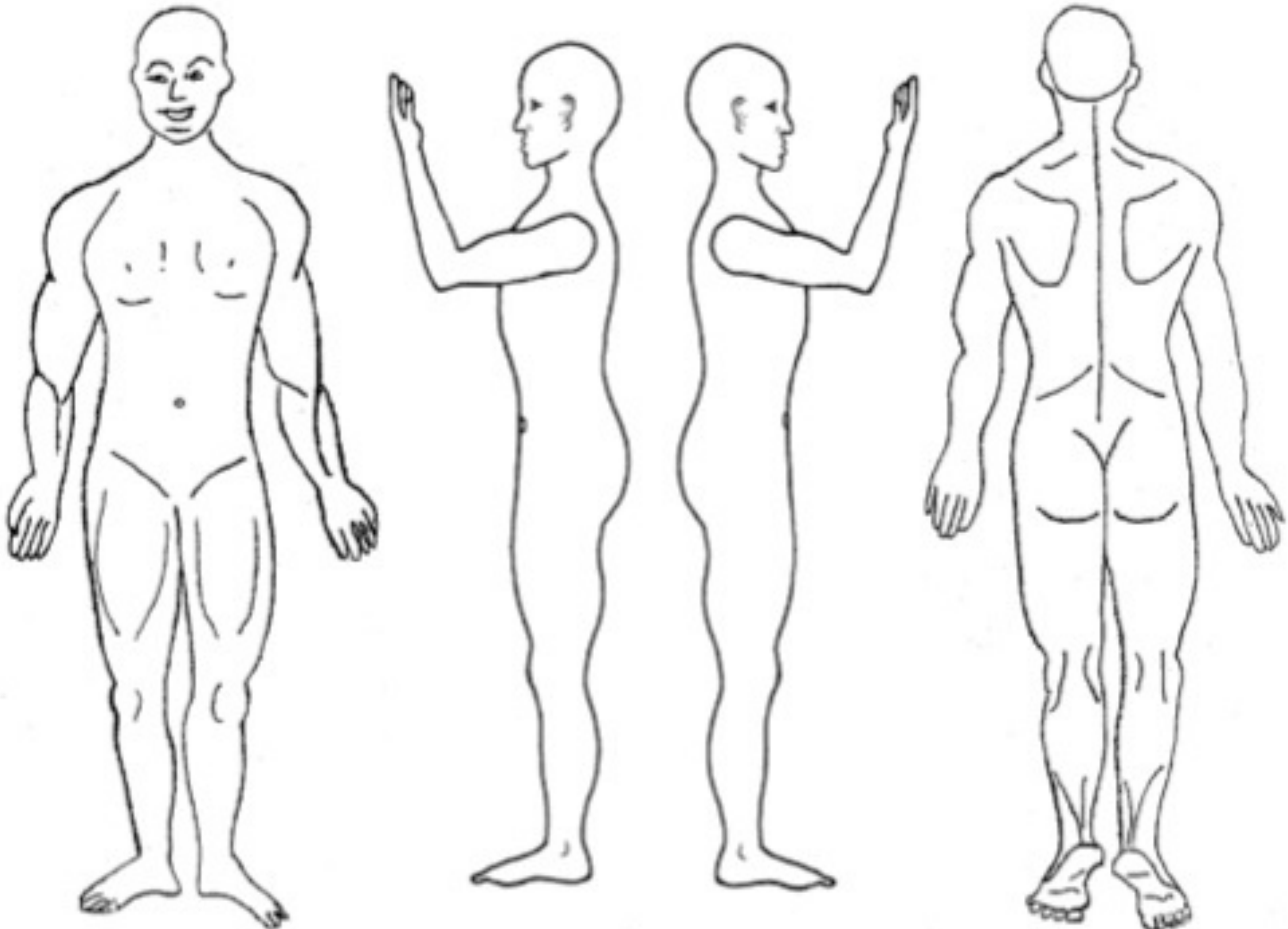
PATIENT AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered, and for missed appointments if I fail to give twenty-four hours notice of cancellation.

Signature: __________________________ Parent / Guardian Signature: _________________ Date: _________

History of Injury / Trauma / Surgery



Directions (Please READ)

<u>All Scars:</u> Please draw a line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, etc.

<u>All Trauma Areas:</u> Please put an "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

<u>Internal Metal:</u> Please draw a circle on the drawing if you have any type of internal metal objects, such as surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

<u>Date of injury and type of injury:</u> Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

Brant A. Larsen, D.C.

PATIENT INFORMATION AND CONSENT FORM

You have agreed to a Chiropractic evaluation, which in this office utilizes Applied Kinesiology for diagnosis as an additional support in conjunction with other standard chiropractic testing procedures.

The practice of Applied Kinesiology was started by Dr. George Goodheart of Detroit, Michigan in 1964 and is today used by some Doctors of Medicine, Osteopathy, Dentistry, and Psychology, as well as Chiropractic, for diagnosis and therapy.

Applied Kinesiology utilizes muscles testing as a supplemental procedure for diagnosis, treatment and/or nutritional recommendations. This procedure is experimental in nature and, while there has been some peer review research and publications of Applied Kinesiology in professional journals, some of the techniques have not been supported by a body of evidence using standard scientific research methodologies.

The Doctor of Chiropractic in this office has received extensive education and training in the use of Applied Kinesiology diagnosis and specialized therapy.

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According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of disease."

A Vitamin is not a drug, *NEITHER* is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

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I have read and understand the use of muscle testing as a diagnostic tool is experimental in nature and agree to an examination utilizing both Applied Kinesiology muscle testing and other standard testing procedures, and to treatment and therapy as agreed upon by myself and the doctor. I also accept responsibility for the acceptance or rejection of any recommendations based on the use of muscle testing.

Patient Name____

Your signature below provides us with authorization to proceed with treatment. If the patient listed above is under the age of 18, a parent or guardian must sign on their behalf and accompany the patient during each appointment.

Signature____ Date______________

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