

# Welcome To Lombard Chiropractic

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
\_\_\_\_ Male \_\_\_\_ Female # of Children \_\_\_\_\_  Single  Married  Significant Other  Widowed  Separated  Divorced  
Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Home # ( ) \_\_\_\_\_ Cellular # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_  
Your employer \_\_\_\_\_ Your occupation \_\_\_\_\_  
Name of Spouse (Parent if patient is under 18) \_\_\_\_\_ Birth Date of Spouse (Parent if patient is under 18) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_ Method of payment for 1<sup>st</sup> Visit: *Cash Check CC*

## Your Health Profile

mark "P" for **PRESENT** CONDITIONS, mark "X" for **PAST** CONDITIONS (3 months or longer), (please 'Circle' if necessary to be more specific)

<input type="checkbox"/> Numbness/Tingling/Pain in (arms / hands / fingers) R / L Both	<input type="checkbox"/> Hip Pain R / L	<input type="checkbox"/> Neck Stiffness/ Pain	<input type="checkbox"/> Back Stiffness/Pain
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Colds / Flu	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Fertility problems
<input type="checkbox"/> Swollen Painful Joints	<input type="checkbox"/> Tremors	<input type="checkbox"/> Blurred Vision R / L	<input type="checkbox"/> Double Vision R / L
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Pain w/ Cough / Sneeze	<input type="checkbox"/> Stroke	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Buzzing/Ringing in ears	<input type="checkbox"/> Sinus Problems/Allergies	<input type="checkbox"/> Nervousness/Anxiety
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability/Mood Swings	<input type="checkbox"/> Tension/Stress
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Recurring Infection	<input type="checkbox"/> Diarrhea/Constipation/Gas
<input type="checkbox"/> Cold feet	<input type="checkbox"/> Asthma/Shortness of Breath	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Jaw/TMJ Problems
<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Problems Urinating	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> PMS	<input type="checkbox"/> Menopause	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Cancer (Type) _____			

Additional Explanation: \_\_\_\_\_

Have you ever been to a chiropractor before? Y / N  
Doctor's name and location \_\_\_\_\_ When was your last adjustment? \_\_\_\_\_

### Current Health Condition

**Primary Complaint:** \_\_\_\_\_

When did condition begin? \_\_\_\_\_ Has it ever occurred before:  Yes  No

Was this due to an accident/trauma?  Yes  No If Yes, explain (fall, sports, auto, work) \_\_\_\_\_

#### **Type of Pain:** (mark all that apply)

Pain  Numbness  Swelling  Muscle spasms  Headache  Tightness  Stiffness  
 Tingling  Weakness

#### **Quality:** (mark all that apply)

Sharp  Dull  Aching  Throbbing  Crushing  Stabbing  Local  Radiating  
 Burning  Migraine  Tension  Hormonal  Sinus  Organ dysfunction

Is there anything that makes it better? \_\_\_\_\_

Is there anything that makes it worse? \_\_\_\_\_

**Severity:** Please circle a level from 0 (no pain) to 10 (disabling pain)

0      1      2      3      4      5      6      7      8      9      10

Does the pain travel or radiate? If so, where? \_\_\_\_\_

#### **Timing:** (mark all that apply)

Is the pain:  Constant  Frequent  Intermittent  Occasional  Infrequent

Is the pain worse in:  Morning  Midday  Night  Consistent all day

**Secondary Complaint:** \_\_\_\_\_

When did condition begin? \_\_\_\_\_

Has it ever occurred before:  Yes  No

**Type of Pain:** (mark all that apply)

- Pain             Numbness     Swelling       Muscle spasms     Headache     Tightness     Stiffness
- Tingling         Weakness

**Quality:** (mark all that apply)

- Sharp             Dull             Aching         Throbbing       Crushing       Stabbing       Local             Radiating
- Burning         Migraine       Tension        Hormonal       Sinus           Organ dysfunction

Is there anything that makes it better? \_\_\_\_\_

Is there anything that makes it worse? \_\_\_\_\_

**Severity:** Please circle a level from 0 (no pain) to 10 (disabling pain)

0      1      2      3      4      5      6      7      8      9      10

Does the pain travel or radiate? If so, where? \_\_\_\_\_

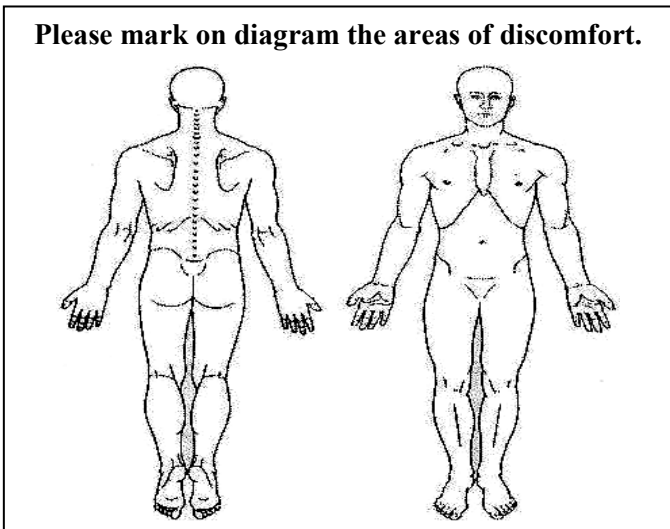
**Timing:** (mark all that apply)

Is the pain:             Constant         Frequent         Intermittent     Occasional       Infrequent

Is the pain worse in:     Morning         Midday           Night             Consistent all day

**DAILY ACTIVITIES:** On a 0-10 scale, please write a number from 0 (no pain) to 10 (disabling pain) on each line below (Please write N/A if not applicable)

- |                          |                  |                      |
|--------------------------|------------------|----------------------|
| Bending ____             | Carrying ____    | Climbing stairs ____ |
| Concentrating ____       | Dancing ____     | Doing Chores ____    |
| Computer work ____       | Dressing ____    | Driving ____         |
| Gardening ____           | Lifting ____     | Playing sports ____  |
| Pushing/pulling ____     | Reading ____     | Rolling over ____    |
| Running/jogging ____     | Shoveling ____   | Sitting ____         |
| Sitting to standing ____ | Sleeping ____    | Standing ____        |
| Walking ____             | Watching TV ____ | Working ____         |



Please list the past 4 traumas you have experienced (any and all of the following: auto accidents, falls, concussions, broken bones, childhood injuries, surgeries, etc.) and approximate date:

1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

Are there any other complaints/conditions that the doctor should address? If so, list & describe: \_\_\_\_\_

**Medications:** What medications are you currently taking and for what conditions? \_\_\_\_\_

What is your objective with coming to our office?     Family Wellness Care     Spinal maintenance     Symptom relief

What solutions have you attempted to solve this problem? \_\_\_\_\_

**Commitment:** Please circle the level that corresponds with your commitment to your overall health and wellness

0%    10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

*I hereby certify the statements & answers given on this form are accurate to the best of my knowledge. I agree to allow this office to perform an evaluation.*

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

# Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements. I therefore begin my chiropractic examination and any further care on this basis.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

\_\_\_\_\_  
(Signature) (Date)

## Consent to evaluate and adjust a minor child:

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

## Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_  
(Signature) (Date)

Lombard Chiropractic • 1127 S. Main St. •  
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www.lombardchiropractic.com

# Family Health History

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus & Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>