HARMONY
Integrated Chiropractic

Fill out this form to the best of your knowledge. Everything you document will be held confidential. The more information I know about you and your conditions, the better I will be able to help you. Do not leave any questions blank: if you are unsure then indicate with a '?' and we will elaborate during your consultation.

Getting to know you:

Name:		**Date of Birth: / /**	**Age:**
Address:	**City:**	**State**	**Zip:**
Email:		**Phone #:**	
Marital Status:	**Spouse's Name:**		**Number of children:**
Name and # of Emergency Contact:			**Relationship:**
Primary Care Provider:			

1. **What are your goals for beginning care with Harmony?**

   _____
   _____
   _____

2. **What are the obstacles preventing you from achieving these goals?**

   _____
   _____
   _____

3. **How willing are you to embrace lifestyle changes to help your body heal and adapt more optimally?**

   _____
   _____
   _____

Current conditions:

Please use the following boxes to briefly explain your current conditions for which you are seeking care. List them in order of priority.

Primary Concern: _____

1. **How would you describe this pain?** (circle all that apply)

Sharp Dull Achy Numb Tight Burning Gnawing Itching

2. **On a scale from 0 to 10 with 10 being the absolute worst pain imaginable, how would you rate this pain?**

No pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst pain

3. **When did this pain begin?** (Be as accurate as you can)

_____

4. **Have you experienced this before? If so, when did it first happen?**

_____

5. **Did any accidents, Traumas, or falls cause this injury? If so, explain.**

_____

_____

6. **Has your problem been getting better, worse, or staying the same?**

Better Worse Same

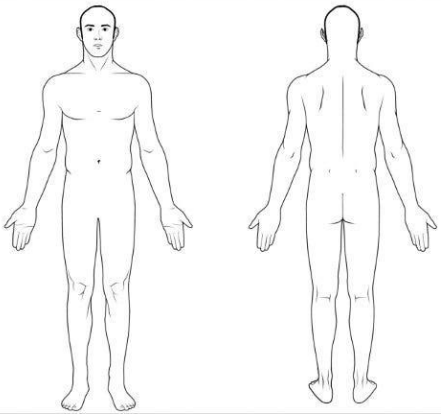
7. **Have you seen anyone else for this condition? If so, who?**

_____

8. **Does this issue prevent you or make it difficult to do anything that you would like to do?**

_____

Indicate on the body where this pain is located:



_____
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Use the space below to list any other conditions that you would like addressed.

_____

_____

_____

_____

_____

_____

Family History:

Please indicate to the best of your knowledge if your parents or grandparents have any of the following conditions. If so, please list the family member under that condition.

1. **Cancer** _____
2. **Heart Disease** _____
3. **Stroke** _____
4. **Diabetes** _____

Social History:

1. **Do you use any nicotine products?** Yes No

   If yes, which types do you use and how often? _____

2. **Do you drink alcohol?** Yes No

   If yes, how much and how often? _____

3. **Do you use any recreational drugs?** Yes No

   If yes, explain which types and how often. _____

Occupation:

1. What is your occupation? _____
   - Since when? _____
2. Employer _____

3. Is your job physically and/or mental stressful? Mentally Physically Neither

4. Circle any and all activities that you do frequently while at work and home.

   Sitting Standing Bending Squatting Lifting Reaching

   Driving Twisting Climbing Running Pulling Hunching

Past History:

Please indicate if you have been diagnosed with any of the following conditions. P = Past C = Current N = Never

____ Broken Bones ____ Dislocations ____ Cancer/ Tumors ____ Rheumatoid Arthritis

____ Osteoporosis ____ Diabetes ____ High Blood Pressure ____ Stroke

____ Disc Herniation ____ Vertigo ____ PTSD Other: _____

List ALL surgeries and operations.

Type of Operation?	When?	Any Metal/Hardware?	Complications?
1.			
2.			
3.			
4.			
5.			
6.			

List all major physical traumas and accidents. E.g. Car accidents, slips, falls, sports injuries, etc.

Accident/Trauma	When? (year or age)	Were you injured?	Hospitalization?
1.			
2.			
3.			
4.			
5.			
6.			

Sleep:

1. **How would you describe your quality of sleep?** (circle one)

   Poor Bad Fair Good Great

2. **How many hours of sleep do you experience per night on average?** _____ hours.

3. **Do you wake up throughout the night?** _____ Yes _____ No

4. **Do you feel rested when you wake?** _____ Yes _____ No

Indicate whether you experience any of the following; (circle all that apply)

Insomnia Nightmares Night terrors Night sweats Night pain

Sleep paralysis Sleep Apnea Teeth Grinding

List any other sleep related issues you experienced that are not included above.

_____

Review of Systems:

Fill out the following to the best of your ability. Please use the following key. P = Past C = Current N = Never

	P	C	N		P	C	N
Skin				**Gastrointestinal**			
- Rashes				- Change in appetite			
- Itching				- Problems swallowing			
Eyes				- Nausea			
- Blurry Vision				- Heartburn			
- Double Vision				- Vomiting			
- Loss of Vision				- Bloating			
- Pain in/around eyes				- Constipation			
Ears				- Diarrhea			
- Ear pain				- Abdominal pain			
- Ringing				- Hemorrhoids			
- Hearing loss				**Urinary**			
- Dizziness				- Difficult/painful urination			
Nose				- Frequent urination			
- Nose bleeds				- Incontinence			
- Frequent colds				- Blood in urine			
Allergies				- Kidney Disease			
- Food				- Hx of kidney stones			
- Asthma				**Musculoskeletal**			
- Hives				- Arthritis			
Lungs/Heart				- Swelling			
- Shortness of breath				- Sprains			
- Cough				- Fractures			
- Wheezing				- Dislocations			
- Chest pain				**Neurological**			
- Fever				- Seizures			
- Night sweats				- Loss of consciousness			
- Hand/feet swelling				- Weakness			
- High blood pressure				- Tremor			
- Heart disease				- Involuntary movement			
- Lung disease				- Numbness			
- Easy bruising				- Tingling (pins and needles)			
Head				**Psychiatric**			
- Headaches				- Anxiety			
- Migraines				- Depression/suicide			
- Concussions				- Memory problems			
Endocrine				- Emotional Traumas			
- Heat/cold intolerance				- Quick fluctuations in mood			
- Diabetes				- ADD/ADHD			
Women Only				**Oral**			
- Irregular/painful Menstruation				- Tooth decay			
- Loss of period (other than menopause)				- Missing teeth			
- Monthly fluctuations in mood				- Pain in mouth			
- Menopause				- TMJ dysfunction/pain			
- Hysterectomy				- Teeth grinding			