

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. other: _____

Last: _____ First: _____ Middle: _____

Birth Date: ___/___/___ Age: _____ Sex: Male / Female

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ ext _____ Cell Phone: (____) _____ - _____ ext _____

Email Address: _____ Spouses Name: _____

In the event we need to contact you, what is the best method of communication? *Phone E-Mail Text*

Children (Names and Ages): _____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Internet/ YFC website Yellow pages Drove by Physician Insurance Plan

Emergency Contact

Name: _____

Phone # (____) _____ - _____ Relationship: Spouse Relative Friend Other _____

Employment Information

Business Name: _____

Occupation/Job Title and Description: _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ___/___/___

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

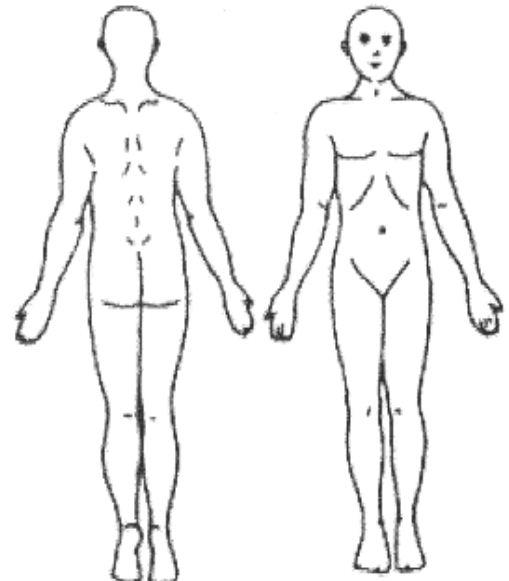
Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



Review of Systems: CIRCLE all CURRENT and PAST conditions. List any health conditions that are not shown below. Even if a condition seems unrelated to care, please check. These may affect your overall care.

- | | | | |
|-------------------------------------------|----------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> high / low blood pressure | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> diarrhea/ constipation: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> anxiety / stress | <input type="checkbox"/> heartburn | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> frequent colds |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> numbness | <input type="checkbox"/> fatigue | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> headaches | <input type="checkbox"/> currently pregnant | <input type="checkbox"/> Other: |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> traumatic birth -your own | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> Other: |

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you taken?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you taken?

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--------------------------------------------------|-------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | <input type="checkbox"/> other: |

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|-------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (severe) |

- fall (severe)
- joint injury
- other:
- fracture
- laceration (severe)
- other:

Family History:

We know that many health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them? _____

Social History: Mark all that apply below.

- Alcohol: do not drink alcohol social consumption only drink regularly, quantity of ____ glasses per ____
- My Dietary Intake consists mainly of the following: (mark all that apply)
 - high fat high salt low fiber low sugar low salt
 - high fiber low carbohydrate
- Tobacco: Do not use tobacco Live with a smoker Quit smoking Smoke/ Chew

Goals For My Care:

People see Chiropractors for a variety of reasons. Some go for Relief Care, to address their symptom, disease, or condition. Some go to Correct/Stabilize the cause of their symptom, disease, or condition. And some choose Wellness Care, so they can prevent future problems and maximize their health and well-being. Your Doctor will make optimal recommendations, based on your health and what your body needs.

We would like to know what your goals are.

- Relief Care** – Treatment designed to address an obvious symptom, disease, or condition
- Stabilization Care** – Continue with the care necessary to fully heal soft tissues and muscles
- Wellness Care** – Non-symptomatic or maintenance care, designed to maximize optimum spinal and nervous system function and help prevent disease.

Are we coordinating care with your physician?:

I would like a copy of my records sent to my physician YES NO

(circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other
 Doctor: _____ Clinic's Name and Location: _____

Financial Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Yost Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Yost Family Chiropractic will be credited to my account upon receipt. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me by Dr. Heather. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card listed below. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If payment hasn't been received in 10 days from terminating care, I authorize deduction from my credit card.

MasterCard/Visa Account # : ***Please have available when checking in at front desk.***

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Yost and/or other licensed doctors of chiropractic who now or in the future work at Yost Family Chiropractic Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
 Consent to treat a Minor - Guardian or Spouse's Signature of Authorizing Care: _____

Auto Accident Details

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger

What are your current symptoms? Pain Numbness Stiffness Weakness

Date of Accident ____/____/____

Patient was located: Driver Passenger- middle front Passenger- right front
 Passenger- left rear Passenger- middle rear Passenger -right rear

Patient Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Second Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Third Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Road Conditions: Clear Dark Dry Foggy Icy Wet

Road Type: Asphalt Concrete Dirt Gravel

Were you aware the accident was going to occur? Yes No

Were you wearing a seatbelt? Yes No

Did your airbag deploy? Yes No

Does your car have a head rest? Yes No

What position was the head rest in? Up Middle Down

Patient's Head Position: Looking Straight Ahead Left Level Left Up Left Down
 Right Level Right Up Right Down Looking Up Looking Down

Accident Details

Was your car braking? Yes No Was your car moving? Yes No

If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the second vehicle braking? Yes No Was the second vehicle moving? Yes No

If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the third vehicle braking? Yes No Was the third vehicle moving? Yes No

If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details

First Impact: hit by other vehicle hit other vehicle hit by object hit object

Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Second Impact: hit by other vehicle hit other vehicle hit by object hit object

Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Collision Results

Body was thrown: Forward Backward Left Right Can't Remember

Head Hit: airbag front windshield rearview mirror steering wheel
 dashboard back of the front seat side window/door another person's body headrest

Chest Hit: airbag steering wheel dashboard back of the front seat
 side window/door another person's body

Shoulders Hit: shoulder harness side window/door back of front seat another person's body

Knees Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Hips Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Vehicle Damage

Patient Vehicle: totaled significant damage light damage no damage
Second Vehicle: totaled significant damage light damage no damage
Third Vehicle: totaled significant damage light damage no damage

Hospitalized

Were you hospitalized? Yes No. If yes, please answer the questions below.

When were you hospitalized? immediately later same day next day date _____

How were you transported to the hospital? ambulance life flight private transportation

What did the hospital recommend? no instructions see this clinic see DC
 see own doctor see orthopedist see neurologist prescription medication
 other: _____

Did you have any xrays taken? Yes No

If yes, what areas? _____

