[REAL] HEALTH SOLUTIONS
at
ribley family chiropractic

Name: Birthdate: Date: Pt. ID:

CHIEF COMPLAINT

1. Reason for Seeking Chiropractic Care:

____

2. Is your condition: ☐ the result of an accident or injury?

☐ Work ☐ Auto ☐ Other______________________

☐ a worsening long-term problem?

3. Onset: When did you first notice your symptoms?

____

4. Intensity: How extreme are your symptoms?

1 5 10
☐☐☐☐☐☐☐☐☐☐
absent———painful——-agonizing

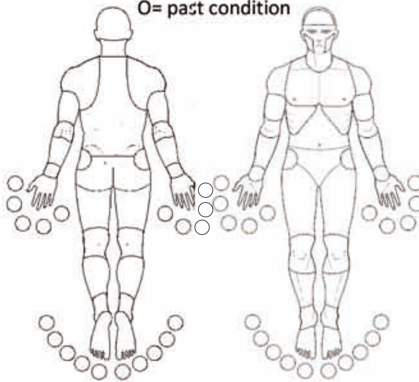
5. Duration/Timing: When and how often do you feel it? ☐Constant ☐Sometimes
Worse in the: ☐Morning ☐Evening
Better in the: ☐ Morning ☐ Evening

6. Quality of Symptoms: What does it feel like?

☐ numbness
☐ tingling
☐ stiffness
☐ dull
☐ aching
☐ cramping
☐ nagging
☐ sharp
☐ burning
☐ shooting
☐ throbbing
☐ stabbing
☐ Other______________________

7. Location: Where does it hurt?

X= current condition
O= past condition



8. Radiating: To what areas does the pain radiate, shoot or travel?

____

9. Aggravating/Relieving Factors: What makes it worse, such as time of day, movement or certain activities?

What worsens the problem?

____

What lessens the problem?

____

10. Prior Interventions: What have you done to relieve the symptoms?

☐ Medication ☐ Surgery
☐ Ice/Heat ☐ Acupuncture
☐ Homeopathic Remedies ☐ Chiropractic
☐ Physical Therapy ☐ Massage
☐ Other______________ ☐ Stretching/Exercise

11. What else should the doctor know about your current condition?

____

12. How does your current condition interfere with your:

Work or career:______________________________

Recreational activities:______________________________

Household chores:______________________________

Personal interactions:______________________________

CONSULTATION NOTES

REVIEW OF SYSTEMS

13. Review of Systems: Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

A. Musculoskeletal: ☐None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck Pain	☐	☐	Back Problems	☐	☐	Hip Disorders
☐	☐	Knee Injuries	☐	☐	Leg pain	☐	☐	Poor posture	☐	☐	Arm Pain	☐	☐	TMJ	☐	☐	Shoulder Pain

B. Neurological: ☐None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins/Needles	☐	☐	Numbness

C. Cardiovascular: ☐None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	High Cholesterol	☐	☐	Poor Circulation	☐	☐	Angina	☐	☐	Excessive Bruising

D. Respiratory: ☐None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay Fever	☐	☐	Shortness of breath	☐	☐	Pheumonia

E. Digestive: ☐None

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia/ Bulimia	☐	☐	Ulcer	☐	☐	Food Sensitivities	☐	☐	Heartburn	☐	☐	Constipation Or Diarrhea	☐	☐	Ulcerative Colitis

REVIEW OF SYSTEMS

F. Sensory: ☐ None

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐ Blurred Vision	☐	☐ Ringing in ears	☐	☐ Hearing loss	☐	☐ Chronic Ear Infections	☐	☐ Loss of Smell	☐	☐ Loss of taste

G. Integumentary: ☐ None

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐ Skin cancer	☐	☐ Psoriasis	☐	☐ Eczema	☐	☐ Acne	☐	☐ Hairloss	☐	☐ Rash

H. Endocrine: ☐ None

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐ Thyroid Problems	☐	☐ Immune Disorders	☐	☐ Hypoglycemia	☐	☐ Frequent Infection	☐	☐ Swollen Glands	☐	☐ Low energy

I. Genitourinary: ☐ None

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐ Kidney stones	☐	☐ Infertility	☐	☐ Kidney Dysfunction	☐	☐ Prostate Problems	☐	☐ Erectile Dysfunction	☐	☐ PMS symptoms

J. Constitutional: ☐ None

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐ Fainting	☐	☐ Low Libido	☐	☐ Poor Appetite	☐	☐ Fatique	☐	☐ Sudden Weight change	☐	☐ Weakness

PERSONAL HISTORY

Past, Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments.

14. Illnesses

Had	Have
☐	☐ AIDS
☐	☐ Alcoholism
☐	☐ Allergies
☐	☐ Arteriosclerosis
☐	☐ Cancer
☐	☐ Chicken pox
☐	☐ Diabetes
☐	☐ Epilepsy
☐	☐ Glaucoma
☐	☐ Goiter
☐	☐ Gout
☐	☐ Heart disease
☐	☐ Hepatitis
☐	☐ Malaria
☐	☐ Measles
☐	☐ Multiple sclerosis
☐	☐ Mumps polio
☐	☐ Rheumatic fever
☐	☐ Scarlet fever
☐	☐ STD
☐	☐ Stroke
☐	☐ TB
☐	☐ Typhoid fever
☐	☐ Ulcer
☐	☐ Other:

____

____

15. Surgery:

Had	Have
☐	☐ Appendectomy
☐	☐ Bypass surgery
☐	☐ Cancer
☐	☐ Cosmetic surgery
☐	☐ Elective surgery
	______________________
☐	☐ Eye surgery
☐	☐ Hysterectomy
☐	☐ Pacemaker
☐	☐ Spine
	______________________
☐	☐ Tonsillectomy
☐	☐ vasectomy
☐	☐ Other
	______________________

17. Injuries:

Have you ever...

- ☐ Had a fracture or broken bone
- ☐ Had a spinal nerve disorder
- ☐ Been knocked unconscious
- ☐ Been injured in an accident
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Received a tattoo
- ☐ Had a body piercing

16. Treatments:

Check the ones you've received in the past and are receiving now.

Past	Now
☐	☐ Acupuncture
☐	☐ Antibiotics
☐	☐ Birth control pills
☐	☐ Blood transfusions
☐	☐ Chemotherapy
☐	☐ Chiropractic care
☐	☐ Dialysis
☐	☐ Herbs
☐	☐ Homeopathy
☐	☐ Hormone replacement
☐	☐ Inhaler
☐	☐ Massage therapy
☐	☐ Physical therapy
☐	☐ Nutritional supplements (list)
	______________________
	______________________
	______________________
☐	☐ Medication: (list)
	______________________
	______________________
	______________________

FAMILY

18. Family History

Please give the history of your immediate family members.

Relative	State of Health Good	State of Health Poor	Illnesses	Age at death	Cause of death Natural	Cause of death Illness
Mother	☐	☐	______	______	☐	☐
Father	☐	☐	______	______	☐	☐
Sister 1	☐	☐	______	______	☐	☐
Sister 2	☐	☐	______	______	☐	☐
Brother 1	☐	☐	______	______	☐	☐
Brother 2	☐	☐	______	______	☐	☐

19. Are there any other hereditary health issues that you know about? ______________________

LIFESTYLE

20. Lifestyle History

Alcohol use	☐ Daily	☐ Weekly	How much? ________
Coffee use	☐ Daily	☐ Weekly	How much? ________
Tobacco use	☐ Daily	☐ Weekly	How much? ________
Exercise	☐ Daily	☐ Weekly	Type________
Water	☐ Daily	☐ Weekly	How much? ________
Vitamins	☐ Daily	☐ Weekly	Type________

Females: Is it possible that you are pregnant?

☐ YES ☐ NO

First day of last cycle:________________

CONSULTATION NOTES

LIFESTYLE

21. What is the primary stressor in your life? ______________________
23. How much sleep do you get per night?________
22. In what position do you sleep most often?______________________
25. Do you drink a half gallon of water per day? Y N
23. What would be the most significant thing you could do to improve your health?

____

24. Do you have any specific health goals?______________________________

ACTIVITIES OF DAILY LIVING

25. Activities of Daily Living:
How does your condition interfere with your ability to function?

	No Affect	Moderate Affect	Severe Affect
Sitting	☐	☐	☐
Rising out of chair	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Bending over	☐	☐	☐
Climbing stairs	☐	☐	☐
Using a computer	☐	☐	☐
Getting in/out of car	☐	☐	☐
Driving	☐	☐	☐
Looking over shoulder	☐	☐	☐
Caring for family	☐	☐	☐

	No Affect	Moderate Affect	Severe Affect
Grocery shopping	☐	☐	☐
Household chores	☐	☐	☐
Lifting objects	☐	☐	☐
Reaching overhead	☐	☐	☐
Showering or bathing	☐	☐	☐
Dressing self	☐	☐	☐
Getting to sleep	☐	☐	☐
Staying asleep	☐	☐	☐
Concentrating	☐	☐	☐
Exercising	☐	☐	☐
Yard work	☐	☐	☐
Endurance	☐	☐	☐

CONSULTATION NOTES

OFFICE POLICIES

TERMS OF ACCEPTANCE

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, to detect and correct/reduce the vertebral subluxation complex. It is important that each patient understand both the objective and the method that will be used 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 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 caused 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 disease any condition other than vertebral subluxation. 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.

It is understood and agreed the amount paid to Ribley Family Chiropractic for x-ray, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Ribley Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

MASSAGE CANCELLATION POLICY

A 24-hour notice is required for canceling massage appointments. Since our therapist are only compensated for their scheduled massages, failure to give a 24-hour notice for cancellation will result in a broken appointment fee of $30 out of pocket, regardless if your insurance usually covers massages. If a spouse or child takes the appointment for you the fee will be waived.

If you arrive late for a massage appointment your finish time will not be extended. Your massage will end at the scheduled time. If you arrive more than 10 minutes late you will not receive a time extension and will be charged for the full time scheduled. If your massage is usually covered by insurance then you will be responsible for a $15 out of pocket late fee.

I ____________________________________,have read, understand and hereby request chiropractic care and agree to comply by the above policies.

Date: ______________________ Signature:______________________________________

Signature of parent or guardian if minor:______________________________________