



Pomperaug Chiropractic AND HOLISTIC CENTER, PC

3 Pomperaug Office Park, Suite 103
Southbury, CT 06488 (203) 264-3583

*You ought not to attempt to cure
eyes without head, or head without body,
so you should not treat body without soul*

- Socrates

Patient History

First Name _____ Last Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work phone _____ Cell _____ E-Mail _____

Date of Birth _____ Age _____ Social Security # _____

Occupation _____ Employer _____

Marital Status: S M D W Number of Children _____ Ages _____

Ethnicity _____ Race _____ Preferred Language _____

Referred By _____ and _____

Name of Emergency Contact _____ Phone # _____

Insurance

Insurance Co. _____ Name of Insured _____

Date/Birth _____ ID # _____ Group # _____

Employer _____

Is your visit related to an accident: Automobile; Work; Potential Legal Litigation?: Y/ N

Chiropractic Treatment Consent

I hereby request and consent to integrative patient care at the Pomperaug Chiropractic & Holistic Center, PC including Chiropractic, Acupuncture and Naturopathic Medical services. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and naturopathic care there are some risks including, but not limited to, fractures, disk injuries, dislocations, strains and sprain and allergic reaction. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interest, based upon the facts as they are then known.

Patient's Signature _____ Date _____

(Parent or guardian of minor)

Medical Release/Assignment of Benefits

*I authorize Pomperaug Chiropractic & Holistic Center, PC to release any Protected Health Information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Pomperaug Chiropractic Center. I understand that I am fully responsible for any unpaid or unassigned portion of charges incurred at this office. **Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility.***

Patient's Signature _____ Date _____

(Parent or guardian of minor)

General Health Information

Height _____ ' _____ " Weight _____ lbs. Left Handed Right Handed
Do you consider your self: Underweight; Overweight Just right

<u>Have you ever:</u>	<u>Yes/No</u>	<u>Briefly Explain</u>
Had Chiropractic care?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Had Naturopathic care?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Had a Pacemaker?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Broken Bones?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Been Hospitalized?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Had Surgery?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Had other traumas or injuries?	<input type="checkbox"/> / <input type="checkbox"/>	_____

When was your last complete physical? _____ Blood Tests: Y/N X-rays: Y/N (body-part) _____
Other Tests (describe) _____ Results? _____
Who is your primary doctor? _____ Address _____ Phone _____
Date of last visit to primary doctor: _____ Reason for visit: _____

Family History - all that apply

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List any diseases or health conditions you now have, or have been treated for in the past. (Give a brief description): _____

Reason for your visit today:

I am here for Wellness Care I am here for Lifestyle Change & Nutritional Counseling
 I am here for treatment of pain, injury or condition, describe: _____

Other: _____

When did this problem begin? _____ Cause of Onset: _____

Describe your Complaint: all that apply

Sharp Dull Aching Burning Numbing Shooting Tightness Throbbing Diffuse Tingling
Frequency of Complaint: Continuous Frequent Intermittent Occasional

Rate your symptoms on a scale from 0 – 10: (0=None, 10=Intolerable), please circle: **0 1 2 3 4 5 6 7 8 9 10**

Does your pain radiate or move? Y/N, If so, where? _____

What aggravates your condition/pain? _____

What relieves your condition/pain? _____

Is the condition worse at certain times of the day? Y/N, When? _____

What activities are limited due to your condition? _____

Is the condition getting progressively worse? Y/N _____

Previous doctors or treatments? _____

Any home remedies used? _____

Have you ever had same/similar condition before? Y/N, Explain: _____

Check any of the following symptoms, which you have now or have had in the past.

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Antibiotic use in past 5 years | <input type="checkbox"/> Scoliosis/Spinal curvature |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Arms/Legs | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Fingers/Toes | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Feeling of Anxiety | <input type="checkbox"/> Stomach upset/Ulcers |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Irritable bowel/Colitis |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Shortness of Breath/Asthma | <input type="checkbox"/> Leg/feet cramps at night |
| <input type="checkbox"/> Ears Ring/Buzz | <input type="checkbox"/> Tension/Irritability | <input type="checkbox"/> Unexplained Fever |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eczema/Skin Rashes |
| <input type="checkbox"/> Clench/Grind Teeth | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Severe Menstrual Cramps |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Depression/S.A.D. | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Roving muscle/joint Pain | <input type="checkbox"/> Alcoholism/Addictions | <input type="checkbox"/> Eyes very sensitive to light |
| <input type="checkbox"/> Recent unexplained weight loss | <input type="checkbox"/> Recent change in bowel or bladder function | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Other _____ | |



About Holistic Health Care

As represented by our logo, the body, mind and spirit are interconnected components of whole health. One's optimum health potential will be reached only when a "balance" exists between these three components. Pain and disease are often "symptoms" which result from imbalance in our lives. This form will aid us in discovering symptoms and "dis-ease" which may be related to imbalances in your life. Be assured that immediate referral will be made with the discovery of any disease or symptom which necessitates more immediate and specialized medical care. Those who are in need of more specialized medical intervention will often benefit from the addition of holistic chiropractic health care.



The Body

<u>Lifestyle Factors: (✓)</u>	More than 3X's/day	3X's/day	2X's/day	Daily	Weekly	Occasional	Never	In Past but No Longer
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeinated beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty going to sleep <input type="checkbox"/> or Staying asleep <input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep less than 7 hours per night				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary/Starchy Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processed Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home made Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruits & Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you eat out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Exercise:

I Exercise: Daily 2-3X's /wk 4-6X's /wk 1X/wk < 1X /wk Rarely Never

Describe the type of exercise that you do: _____

List your Prescriptive or non-prescriptive drugs along with the dosage and reason for taking: _____

Do you have any allergies to Prescriptive or non-prescriptive drugs? If so list.: _____

List your vitamins or natural remedies: _____



The Mind

Do you often feel rushed? Y/ N _____

Do you easily lose your train of thought? Y/ N _____

Is it difficult to shut off or slow your thoughts? Y/ N _____

Is it difficult to motivate yourself? Y/ N _____

Do you see a connection between your symptoms and your Emotional state/stress? Y/ N _____

Do your symptoms change or go away while on vacation, away from home, or while distracted? Y/ N _____

Would you describe yourself as: (all that apply)

- Hard on myself
- Laid Back
- Thorough or Meticulous
- Highly responsible for others
- Emotional
- Sensitive
- Relaxed
- Easily Startled
- A worrier
- Fearful
- Highly Conscientious
- Calm
- Caretaker

Rate the level of stress you are experiencing on a scale of 0-10 (0 being no stress): **0 1 2 3 4 5 6 7 8 9 10**

What do you perceive as the source of your stress? (e.g., work, family, finances, legal, self, etc.) _____



The Spirit

	<u>Yes/No</u>	<u>Explain</u>
Do you consider yourself spiritual?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Do you feel a strong sense of purpose?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Are you satisfied with your life?	<input type="checkbox"/> / <input type="checkbox"/>	_____
Do you pray or meditate regularly?	<input type="checkbox"/> / <input type="checkbox"/>	_____

Life Events - Check any of the following that have occurred within the last 3 years

- Death of a Loved One
- Divorce/Separation
- Marriage/Family Additions
- Job/Career Change
- Personal injury/illness
- Illness of a Loved One
- Change of Residence
- Change in Financial Status
- A Difficult Relationship
- Starting/Finishing School
- Child Leaving Home
- Business Difficulties
- Other _____

List any major life events, (good or bad), which you anticipate within the next year: _____

What are your current health Goals? _____