Full Name _____

Birth Date_____ Gender: M F

Address _____

City_____ State_____ Zip_____

Email address: _____ Home Phone: _____

Cell Phone: _____

SS# _____-_____-_____

Are You a Student? Yes No / Full-Time Part-Time

Your Employer_____

Your Occupation_____

Employer Address _____

City_____ State_____ Zip_____

Marital Status: S M W D Sep

Spouse Name_____

Spouse Birth Date_____

Spouse's Employer_____

Spouse's Occupation_____

Referred by: _____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- I give this office authorization to use LexisNexis RiskView for possible financing.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.)
- I understand how my PHI (Private Healthcare Information) may be disclosed by this office and have received a copy of this DPN (Detailed Privacy Notice).

Patient's Signature_____ Date _____

Spouse's/Guardian's Signature_____ Date_____

(Authorization expires 3 years from date above)

FULL NAME_____ DATE _____

HISTORY of PRESENT Injury/Illness. Please list below the complaints you have in the order of importance. Also the length of time you have had these complaints.

1_____ How long? _____

2_____ How long? _____

3. _____ How long? _____

4. _____ How long? _____

Is condition related to an accident? □ Yes □ No Date of accident _____

□ Auto □ Employment □Other _____

Circle the number that matches your pain at its worse (0 = no pain, 10 = most severe)

0 1 2 3 4 5 6 7 8 9 10

What words **best describe** your present condition(s)? (Ex: ache, burn) _____

When is your condition ***most*** severe? _____

When is your condition ***least*** severe? _____

What makes your condition feel ***worse***? _____

What makes your condition feel ***better****?* _____

What activities are difficult because of your condition? _____

Have you seen any other health care provider for your present condition? [ ] YES [ ] NO

Who? _____

Current medications and reasons for meds _____

_____

Have you ever been diagnosed as having a particular condition? (diabetes, heart trouble, cancer)

[ ] Yes [ ] No _____

Are you currently under a doctor's care for conditions other than the ones you are seeking care for?

[ ] Yes [ ] No explain_____

Are you or could you be pregnant? [ ] Yes [ ] No

PAST HISTORY

List any surgeries you have had (including appendix, tonsils, wisdom teeth etc.)

1._____ Date_____

2._____ Date_____

3._____ Date_____

4._____ Date_____

Have you ever been hospitalized? □ Yes □ No When and why _____

Had surgery? □ Yes □ No What operations and when? _____

Had a major or minor fall or accident? □ Yes □ No What and when?_____

Had a cracked or broken bone? □ Yes □ No What and when?_____

Personal habits:

□ Caffeine Amount _____

□ Tobacco Amount _____

□ Alcohol Amount _____

□ Vitamins Kind _____

□ Exercise Amount _____

Family History related to present condition:

_____

_____

RAUCH CHIROPRACTIC & REHAB

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Small Pox
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Pleurisy
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Covid
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Pacemaker
- ☐ Other Problems _____

_____

FEMALES ONLY:

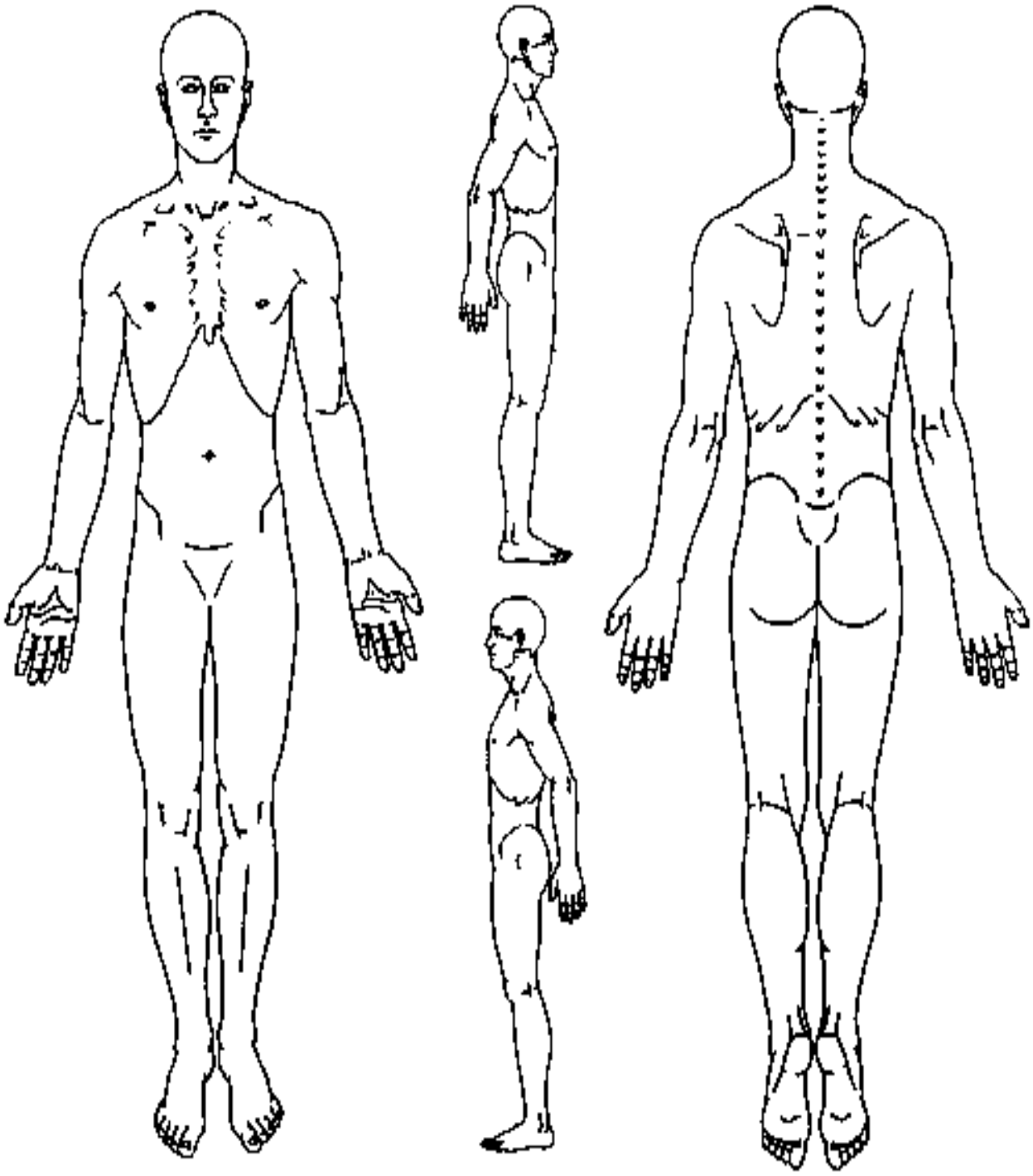
When was your last period?

_____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Child
- ☐ Brother
- ☐ Sister
- ☐ Spouse



Please mark the diagram in the proper location with the type of pain you are experiencing.

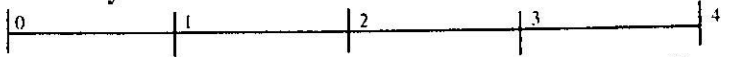
A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

Functional Rating Index

For use with Neck and/or Back Problems only.

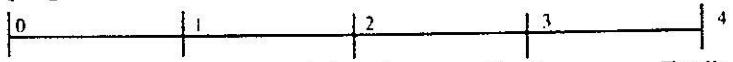
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



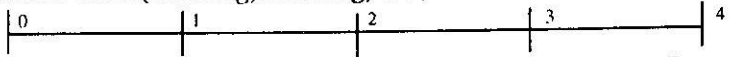
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



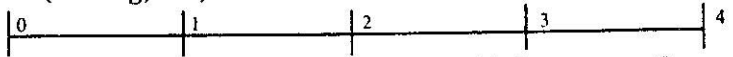
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



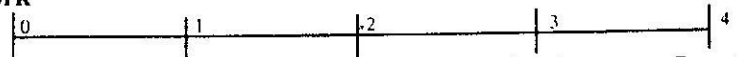
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



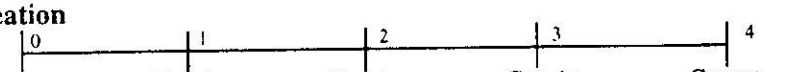
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



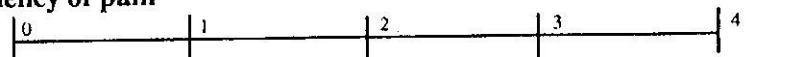
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



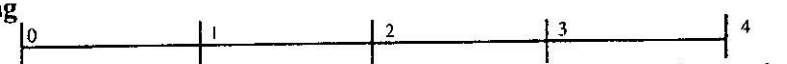
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



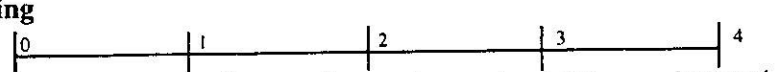
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



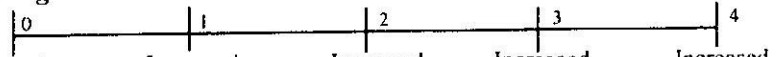
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____ _____

Signature **Date**

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TheHamiltonChiropractor.com

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 for the same objective.

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

Adjustment: The 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 to the spine.

Health: The 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 diagnosis or treat any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination 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 another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ _____
(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 terms of acceptance 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)