ABOUT THE PATIENT

Step Up Chiropractic
2525 S King St, Ste 311, Honolulu, HI 96826

Name _____ Today's Date_____ Birthdate _____ Age_____
Address _____ City _____ State _____ Zip_____
Cell Phone _____ Gender ❑ M ❑ F ❑ Other / prefer not to answer
Occupation _____ Employer _____
e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes
Emergency Contact _____ ph # _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often are symptoms felt (check one): ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Staying the same ❑ Getting worse ❑ Worse in morning ❑ Worse in evening
❑ Pain radiates to_____

2. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often is the pain felt (check one): ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Staying the same ❑ Getting worse ❑ Worse in morning ❑ Worse in evening
❑ Pain radiates to_____

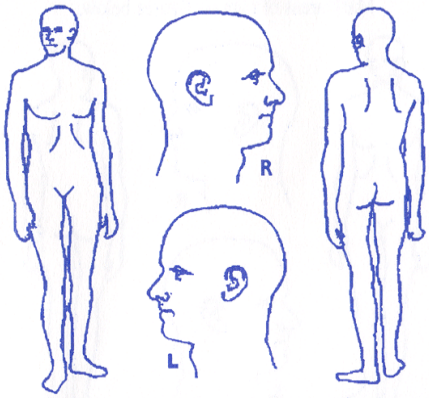
3. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often is the pain felt (check one): ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Staying the same ❑ Getting worse ❑ Worse in morning ❑ Worse in evening
❑ Pain radiates to_____

4. Do you expect any long trips or permanent moves off island that may interfere with adhering to care? _____
5. Does your condition affect: ❑ Standing ❑ Sitting ❑ Walking ❑ Work ❑ Lifting Things ❑ Sleep ❑ Other _____
6. What makes it better?_____
7. What makes it worse? _____
8. What other health practitioners have you seen for this?_____
_____
9. Any other things you have tried to fix this issue:_____
_____

NOTES: _____
_____
_____
_____
_____
_____

Are you pregnant?
❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications you are taking:**_____

_____

2. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** ❑ No ❑ Yes, Name _____

PAST HISTORY

4. **List any past auto collisions:**_____ **Was any care received?** ❑ No ❑ Yes
5. **List any past work injuries:** _____ **Was any care received?** ❑ No ❑ Yes
6. **List major sport, recreational, or home injuries**_____
7. **Please describe other significant conditions and treatment received:** _____

_____

8. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Consents

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Privacy and Sharing of Information

I authorize Step Up Chiropractic and its associated health professionals to collect my personal and medical information. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

_____ _____

Patient's Signature or Parent's Signature If Patient Is Under 18 Date

Consent To Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per million to one per two million cervical spine adjustments is a vertebral artery injury that could lead to a stroke. Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

_____ _____

Patient's Signature or Parent's Signature If Patient Is Under 18 Date