

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

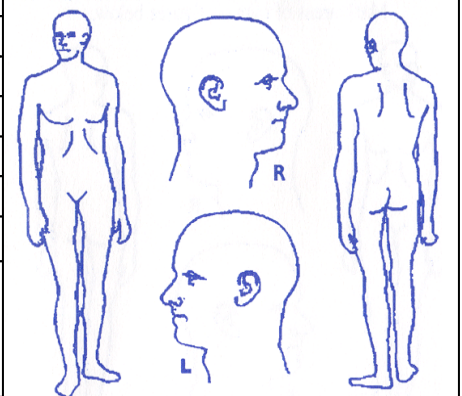
1. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often are symptoms felt (check one): ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Staying the same ☐ Getting worse ☐ Worse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

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Shortness of Breath
- ☐ ☐ Allergies / Asthma
- ☐ ☐ Medication Side Effects
- ☐ ☐ Diabetes
- ☐ ☐ Hands or Feet cold
- ☐ ☐ Muscle aches
- ☐ ☐ Trouble Walking
- ☐ ☐ Leg / Foot Numbness
- ☐ ☐ Fainting
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Ringing in Ears
- ☐ ☐ Ear Problems
- ☐ ☐ Sleeping Problems
- ☐ ☐ Vision Problems
- ☐ ☐ Thyroid Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Kidney Problems
- ☐ ☐ Light Bothers Eyes
- ☐ ☐ Other _____

Past Present

- ☐ ☐ Urinary Problems
- ☐ ☐ Easy Bruising
- ☐ ☐ Tobacco Use
- ☐ ☐ Dental Problems
- ☐ ☐ Fibromyalgia
- ☐ ☐ Blood Thinner use
- ☐ ☐ HIV Positive
- ☐ ☐ Cancer
- ☐ ☐ Depression
- ☐ ☐ Alcohol Use
- ☐ ☐ ___High or ___Low Blood Pressure
- ☐ ☐ Stroke History
- ☐ ☐ High Cholesterol
- ☐ ☐ TMJ
- ☐ ☐ Digestive Problems
- ☐ ☐ Pain all Over
- ☐ ☐ Tension / Irritability
- ☐ ☐ Chest Pains
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Heart Problems

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