



CARLEEN A. THUM, D.C. A WELLNESS PROVIDER RIVER'S EDGE CHIROPRACTIC

Your Health History

Your completion of the paper work that follows will allow me to understand how your body is adapting to the stresses of everyday living.

Your central nervous system (brain and spinal cord) sends messages to every cell, tissue, gland, organ and system in your body. The communication of this spinal neurologic network determines whether you enjoy good health or suffer with problems. Your nerve system can experience interference, injury or disturbance. This blockage of nerve energy is called a subluxation.

Today we will discuss the highlights of your health history, specifically, what types of **physical, chemical and mental or emotional stress** you have experienced over the years. Please take a few moments to recall your stress profile which may include the following experiences:

Physical stress. Examples are birth trauma, slip and fall injuries, auto accidents, sports injuries, work injuries, poor ergonomics at work or during sleep or just plain wear and tear. Multiple physical stresses accumulated over a lifetime may cause damage to your nerve system.

Chemical toxins may have poisoned your nerve system and include everything you ingest or have been exposed to. Since we are a chemically dependent society the list is long and may include food dyes, sweeteners, preservatives, hormones in meats, processed foods, caffeine, nicotine, prescriptive and over the counter drugs, air and water pollutants, cleaning chemicals, hair sprays, etc.

Mental and emotional stress may be occurring now or have happened in the past. Your nerve system filters and processes data on a moment to moment basis. If it becomes overwhelmed by constant or chronic input it may break down. Examples include early childhood stress, chronic worry and anxiety, divorce, moves, illness and/or death of loved ones, problems on the job or at home

Thank you.

Date _____

Name: _____ I Prefer to be called: _____

Address: _____ City: _____ State: _____ Zip _____

Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Email address: _____

It is best to contact me on my Home phone Work phone Cell phone

Date of Birth: _____ Social Security Number: _____

Check Appropriate Box: Minor Single Married Partnered Widowed Separated Divorced

Employer: _____

No. of children: _____ Ages: _____

Reason for consulting our office? _____

Whom may we thank for referring you? _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity for improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (To AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

- Did you have any childhood illnesses?
- Did you have any serious falls?
- Did you play youth sports?
- Did you take/use any drugs?
- Did you fall/jump from a height over 3 feet? (i.e. crib, trees)
- Were you involved in any car accidents as a child?

YES NO UNSURE

-
-
-
-
-
-

- Was there any prolonged use of medicine (such as an inhaler)?
- Did you suffer any other traumas (physical or emotional)?
- Were you vaccinated?
- As a child, were you under regular Chiropractic care?

YES NO UNSURE

-
-
-
-

COMMENTS: _____

ADULT (18 to PRESENT)

- Do/did you smoke?
- Do/did drink alcohol?
- Have you been in any accidents?
- Have you had any surgery?

YES NO UNSURE

-
-
-
-

- Do/did you play any adult sports?
- Do/did you participate in extreme sports?
- On a scale of 1-10 describe your stress level: (1 = none / 10 = extreme)

YES NO UNSURE

-
-

Occupational _____
 Personal _____

On a scale of Poor, Good, Excellent, describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have **no** symptoms or complaints and are here **only** for wellness services, please check here _____ and skip to the section "Family Health Profile." Otherwise, briefly describe your **chief** area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it....

SHARP

DULL

COMES AND GOES

TRAVELS

CONSTANT

Since the problem started, is it....

ABOUT THE SAME

GETTING BETTER

GETTING WORSE

What makes it worse?

Yes, it interferes with: WORK

SLEEP

WALKING

SITTING

HOBBIES

LEISURE

Other Doctors I've seen for this problem (please list):

Chiropractor _____

Medical _____

Doctor _____

Other _____

Please check all symptoms you have ever had for a prolonged period of time, even if they do not seem related to your current condition:

Headaches

Pins and Needles in legs

Fainting

Neck Pain

Loss of smell

Pins and Needles in arms

Back Pain

Loss of Balance

Dizziness

Buzzing in Ears

Ringing in Ears

Nervousness

Loss of taste

Numbness in Fingers

Numbness in Toes

Stomach Upset

Fatigue

Depression

Irritability

Tension

Sleeping problems

Neck Stiff

Cold Hands

Cold Feet

Diarrhea

Constipation

Fever

Hot Flashes

Cold Sweats

Light Bothers Eyes

Problem Urinating

Heartburn

Mood Swings

Ulcers

Menstrual Pain

Menstrual Irregularity

List any medications you are taking:

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being but also how the health and well-being of your family and loved ones affects your health. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature _____

Date _____

CARLEEN A. THUM D.C. P.C., A Wellness Provider
River's Edge Chiropractic
80 Lambert Lane
Lambertville, New Jersey 08530
609-397-4390

Patient Consent Form

A Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a patient's rights section describing your rights under law. You have the right to review this notice before signing this consent. The terms of our Notice may change. If this occurs, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about is used or disclosed for health care procedures and/or payment. You also have the right to revoke this consent in writing. However, such a revocation shall not affect any disclosures we have already made in relation to your prior consent. River's Edge Chiropractic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

Protected health information may be disclosed or used for health care procedures and/or payment.

River's Edge Chiropractic has a Notice of Privacy Practices and I have the opportunity to review the Notice.

River's Edge Chiropractic reserves the right to change the Notice of Privacy Policies.

I have the right to restrict the uses of this information but the River's Edge Chiropractic does not have to agree to this restrictions.

I may revoke this consent in writing at any time and all future disclosures will then cease.

River's Edge Chiropractic may condition treatment upon the execution of this consent.

This consent was signed by: _____

Patient or Representative Signature

Relationship to patient: _____

Date: _____

Office Representative: _____