Golden Sun Chiropractic Wellness Center, PLLC
Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:** Una Forde, D.C.

Name:_____ Home Phone: _____ Cell Phone:_____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Fax: _____

Age:_____ Birth Date:_____ Race:_____ _____ Marital Status: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ❑ Yes ❑ No

Have you been to a chiropractor before? ❑ Yes ❑ No If yes, approximately when was your last visit? _____

Please check any and all insurance coverage that may be applicable in this case**:**

❑ Major Medical ❑ Worker's Compensation ❑ Medicaid ❑ Medicare ❑ Auto Accident
❑ Medical Savings Account & Flex Plans ❑ Other

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____

DATE _____ Doctor__Una Forde, D.C._____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ❑ Yes ❑ No If yes, when and describe:_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ❑ Yes ❑ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes, describe:_____

Do you have any allergies of any kind? ❑ Yes ❑ No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now		P = Previously
Headaches___ Frequency	_____	Loss of Balance	_____
Neck	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PATIENT NAME _____

DATE _____ Doctor__Una Forde, D.C._____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Ulcers	_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____	Vigorous Exercise	_____	Family Pressures
_____	Moderate Exercise	_____	Financial Pressures
_____	Alcohol	_____	Other Mental Stresses
_____	Drug Use	_____	Other (specify)_____
_____	Tobacco Use	_____	
_____	Caffeine		
_____	High Stress Activity		

PATIENT NAME _____

DATE _____ Doctor___Una Forde, D.C._____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Thank you for choosing Golden Sun Chiropractic Wellness Center, PLLC for your health care needs!

www.goldensunchiro.com
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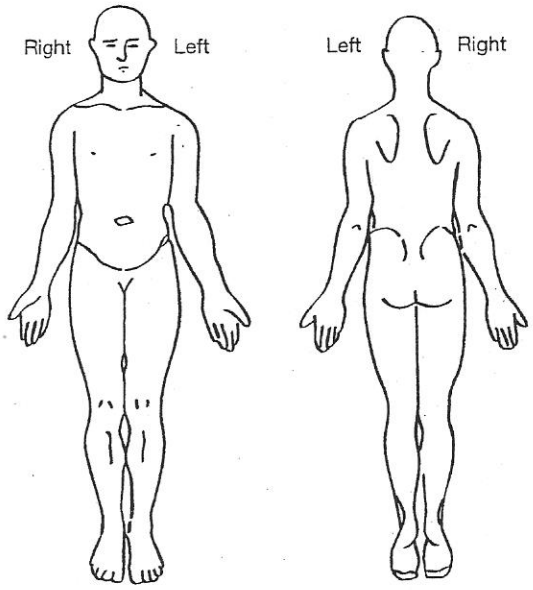
Dr. Una Forde

BRIEF PAIN INVENTORY

Date: ___ / ___ / ___ Time: _____

Name: _____ _____ _____
Last First Middle Initial

On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



1) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

2) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

3) Circle the one number that describes how, during the past 24 hours, pain has interfered with your.

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interfere

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

What does the pain feel like? Circle those words that describe your pain.

nausea	vomiting	constipation
diarrhea	lack of appetite	indigestion
difficulty sleeping	feeling drowsy	nightmares
dizziness	tiredness	itching
urinary problems	sweating	weakness
headaches		