



# Lakes Chiropractic



## Adult and Adolescent Consultation History

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Home: \_\_\_\_\_ Bus: \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_ Health Insurance: \_\_\_\_\_

Children's names & ages: \_\_\_\_\_

Previous chiropractor: \_\_\_\_\_

Last visit: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

Present MD: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

What is your main reason for this visit? \_\_\_\_\_

How long have you suffered with this problem? \_\_\_\_\_

How did it start? \_\_\_\_\_

Could it have been caused by a work injury or an auto accident? \_\_\_\_\_ Please explain: \_\_\_\_\_

What have you tried to do to get rid of this problem? \_\_\_\_\_

What gives you temporary relief? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

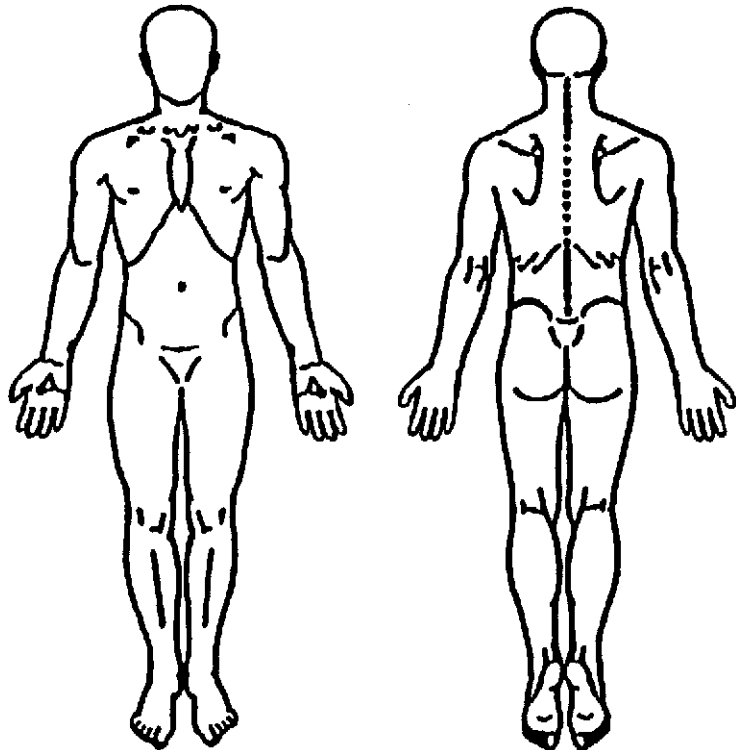
Other Professionals seen for Main Health Concern: \_\_\_\_\_

Treatment and Results: \_\_\_\_\_

Any additional complaints? \_\_\_\_\_

Do you have any health problems we should be aware of?

Show area(s) of pain or unusual feeling.  
Mark the areas on this body where you feel the  
described sensations. .  
Mark areas of radiation. Include all affected areas.



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## THIS SECTION ONLY FOR PREGNANT WOMEN

Have you been to a Chiropractor with a previous pregnancy? \_\_\_\_\_ Names and when \_\_\_\_\_

Is this your first pregnancy? \_\_\_\_\_ How many births have you had? \_\_\_\_\_

How many weeks pregnant are you now? \_\_\_\_\_ What is your due date? \_\_\_\_\_

Have you had any traumas during this pregnancy (slips, falls) \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Are you taking any medications? If yes, please list \_\_\_\_\_

Do you smoke or drink alcohol? \_\_\_\_\_ Who is your birth care provider? \_\_\_\_\_

Where do you plan on delivering? \_\_\_\_\_

Have you had any evaluation procedures (ultrasound, amniocentesis, chronic villus sampling)? \_\_\_\_\_

If yes, please list dates, frequency and reason for these procedures \_\_\_\_\_

Has there been any stressful events in your life during this pregnancy? \_\_\_\_\_

What are your most significant fears associated with this birth? \_\_\_\_\_

Do you have someone with you at birth for support (other than birth care provider) \_\_\_\_\_ If yes please specify who \_\_\_\_\_

Have you put a birth plan together? \_\_\_\_\_

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In case of emergency, please notify: \_\_\_\_\_

Relationship and telephone number: \_\_\_\_\_

At our office we are not only interested in your health and well being, but the health and well being of your family as well.

Please mention any health conditions or concerns you may have about your. . . .

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Other: \_\_\_\_\_

### FOR WOMEN ONLY

Date of your last menstrual period: \_\_\_\_\_

Are you using any means of contraception? If so, what? \_\_\_\_\_

Do you experience severe cramping with your menstrual period? \_\_\_\_\_

Do you suffer from PMS? \_\_\_\_\_

## ***AUTHORIZATION FOR CARE***

I hereby authorize Lakes Chiropractic and its doctors to administer care as they deem necessary. I authorize the doctors to take x-rays, perform an exam and administer treatment. I clearly understand and agree that I am personally responsible for payment of any fees not covered by my insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ***TERMS OF ACCEPTANCE***

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic care has only one goal; which is to obtain optimal health. It is important that each patient understands the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of manual forces to facilitate the body's correcting of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A 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 on the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal exam, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of any findings we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by other. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific manual manipulation of the spine to correct vertebral subluxation.

I, \_\_\_\_\_, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. Therefore I accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please list dates and body locations of any prior surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescription Medication Name	Taken for what condition/symptom	How long taken?
1.		
2.		
3.		
4.		
5.		
6.		

Over the counter medication name	Taken for what condition/symptom	How long taken?
1.		
2.		
3.		
4.		
5.		
6.		

Vitamins/Minerals/Health Supplements	Taken for what condition/symptom	How long taken?
1.		
2.		
3.		
4.		
5.		
6.		