Welcome To Buchar Family Chiropractic

First Name_____MI ____ Last _____ Birth Date____/____/____ Age_____ Today's date____/____/____

Address _____ City _____ State_____Zip _____

Home # ( )_____Work # ( ) _____ Ext._____Cellular # ( )_____

____ Male ____ Female Soc. Sec. # _____-____-_____ E-mail Address _____ Employer _____

# of Children _____ Ages of Children _____ Single Married Significant Other Widowed Separated Divorced

Your occupation _____Work duties_____***WOMEN ONLY: Are you pregnant? No ____ Yes ____***

Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18)_____

Who may we thank for referring you to our office?_____ Method of payment for First Visit: *Cash Check CC*

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both

___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L Both

___Headaches/Migraines
___Fractured Bones
___Swollen Painful Joints
___Anemia
___Pain w/ Cough / Sneeze
___Heart Problems
___Prostate Problems
___Dizziness/Vertigo
___Fatigue
___Colon Trouble
___Cold feet
___Foot Problems
___Cold Sweats
___High Blood pressure
___Other

___Hip Pain R / L
___Arthritis
___Convulsions/Epilepsy
___Tremors
___Chest Pain
___Stroke
___Kidney Trouble
___Buzzing/Ringing in ears
___Depression
___Sleeping Problems
___Bed Wetting
___Shortness of Breath
___Light Sensitivity
___PMS
___Cancer (Type)

___Neck Stiffness/ Pain
___Frequent Colds / Flu
___Skin Problems
___Blurred Vision R / L
___Lung Problems
___Gall Bladder Problems
___Loss of Smell
___Sinus Problems/Allergies
___ Irritability/Mood Swings
___Cold Hands
___Recurring Infection
___Hot Flashes
___Problems Urinating
___Menopause

___Back Stiffness/Pain
___Diabetes
___Cancer
___Double Vision R / L
___Loss of Taste
___Digestive Problems
___Loss of Balance
___Nervousness/Anxiety
___Tension/Stress
___Stomach Upset
___Diarrhea/Constip./Gas
___Jaw/TMJ Problems
___Heartburn/Reflux
___Ulcers
___

Additional Explanation:

Have you ever been to a chiropractor before? Y / N If NO why not?_____

Current Health Condition

Chief Complaint (why you are here today):

_____

_____

When did this condition begin?_____ Has it ever occurred before: Yes No
Was this due to an accident/Trauma? Yes No
If Yes, explain.(ex. fall, auto, sports,)
_____

Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels?_____

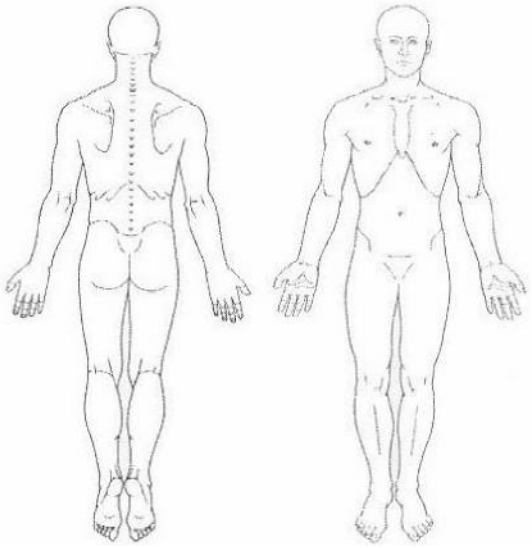
Severity Mild Moderate Severe
Does this pain travel or radiate? If so, Where?_____

Quality: (circle all that apply)

Burning	Diffuse	Dull/Aching	Localized
Sharp	Shooting	Stabbing	Tingling
Radiating	Other _____		

Is there anything that makes this better? _____
Is there anything that makes this worse? _____

Please mark on the diagram below the area of discomfort.



Goals: 1.)_____
2.)_____
3.)_____

Please Mark the Diagram Accordingly Above:
R=Radiating B=Burning D=Dull A=Aching S=Sharp
N=Numbness T=Tingling

Timing:
❑ Worse AM ❑ Worse PM ❑ Worse W/ Activity ❑ Worse Sleeping
❑ Occasional (0-25%) ❑ Intermittent (25-50%) ❑ Frequent (50-75%) ❑ Constant (75-100%)

Rate the severity of your symptoms or condition (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Is the condition getting better, worse, or staying the same? _____

Have you suffered with this or a similar problem in the past? □ No □ Yes If yes how many times? _____ When was the last episode? _____

When was the first? _____ How did the injury happen? _____

What solutions have you attempted to solve this problem? _____

What were the results: □ Favorable □ Unfavorable Please Explain: _____

Secondary Complaint: _____

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Changing Positions	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Reading/Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Standing Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

Please List any effects that this may have on any Recreational Activities:
_____

Are there any other Complaints/Conditions/Past Accidents & Surgeries that the doctor should address? If so, list and describe**:**

_____
_____
_____

Medications: What Medications are you currently taking and for what Conditions?

_____
_____

Is there anything else you think the doctor should know concerning your condition? Yes No

_____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

____ Temporary Relief (Symptomatic) ____ Maximum Correction (Correct the problem & reduce chance of reoccurrence)

The questions below will allow us to better serve you.
What is most important to you when it comes to your relationship with your health care provider and your overall office experience?_____
Would you say you are open and interested in new and cutting edge health care practices or more comfortable with conventional approaches? _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction 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 of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a 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 evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those 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 others.

HIPPA

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I,_____have read and fully understand the above statements.
(Print name)

I therefore begin my chiropractic examination and any other further care on this basis.

_____ _____

(Signature) (Date)

buchar family chiropractic
Natural Health for life!

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for their review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Difficulty Sleeping							
Disc Problems							
Ear Problems							
Emphysema							
Epilepsy/Seizures							
Fatigue							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neck Pain							
Numbness							
Pinched Nerve							
Scoliosis							
Sinus & Allergies							
Stomach Trouble							

Buchar Family Chiropractic | 3015 E. New York St. Suite A-11 | Aurora, IL 60504
Tel (630) 820-1330 | Fax (630) 820-1554 | www.bucharfamilychiro.com