LeMay CHIROPRACTIC & WELLNESS

Confidential Health History Information

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Today's date: _____

PERSONAL INFORMATION

Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Height: _____ Weight: _____ lbs.

Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Preferred Language: _____

Phone: Home: _____ Cell: _____ Work: _____

May we contact you at work? ☐ Yes ☐ No Preferred method of contact? ☐ Home ☐ Cell ☐ Work ☐ Email

Occupation: _____ Employer: _____

Emergency Contact: _____ Emergency Contact's Phone: _____

Spouse Name: _____

Child Name: _____ Age: _____ Child Name: _____ Age: _____

Child Name: _____ Age: _____ Child Name: _____ Age: _____

Whom may we thank for referring you? _____

Have you consulted a chiropractor/nutritionist before? ☐ Yes ☐ No If so, whom? _____

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The symptom(s) that have prompted me to seek care today include:

And are the result of:

☐ An accident or injury

☐ Work ☐ Auto ☐ Other:

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other:

Onset (When did you first notice your current symptoms)

Intensity (How extreme are your current symptoms)

LOW | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | HIGH

Duration and timing (When did it start and how often do you feel it?)

☐ Constant ☐ Comes and goes How Often?

Quality of symptoms (What does it feel like?)

☐ Numbness ☐ Nagging

☐ Tingling ☐ Sharp

☐ Stiffness ☐ Burning

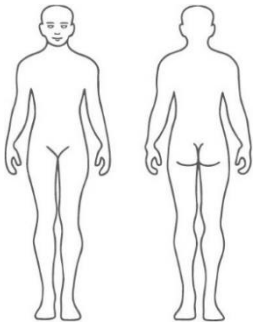
☐ Dull ☐ Shooting

☐ Aching ☐ Throbbing

☐ Cramps ☐ Stabbing

☐ Other:

Location (Where does it hurt?)



Mark the area(s) where you have pain

O for current condition

X for conditions experienced in the past

Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?

What tends to lessen the problem?

Prior interventions (What have you done to relieve the symptoms?) If none apply below check this box

☐ Prescription medication ☐ Physical therapy ☐ Chiropractic ☐ Ice

☐ Over-the-counter drugs ☐ Surgery ☐ Massage ☐ Heat

☐ Homeopathic remedies ☐ Acupuncture ☐ Other:

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What else should Dr. LeMay know about your current condition?

How does your current condition interfere with your:

Work or career:

Recreational activities:

Household responsibilities:

Personal relationships:

Review of symptoms

Please mark any condition that you've **Had** or currently **Have** and initial to the right.

Musculoskeletal	Neurological	Cardiovascular	Respiratory	Digestive
Had Have	Had Have	Had Have	Had Have	Had Have
☐ ☐ Osteoporosis	☐ ☐ Anxiety	☐ ☐ Highblood pressure	☐ ☐ Asthma	☐ ☐ Anorexia/bulimia
☐ ☐ Arthritis	☐ ☐ Depression	☐ ☐ Lowblood pressure	☐ ☐ Apnea	☐ ☐ Ulcer
☐ ☐ Scoliosis	☐ ☐ Headache	☐ ☐ High cholesterol	☐ ☐ Emphysema	☐ ☐ Food sensitivities
☐ ☐ Neck pain	☐ ☐ Dizziness	☐ ☐ Poor circulation	☐ ☐ Hay fever	☐ ☐ Heartburn
☐ ☐ Back problems	☐ ☐ Pins and needles	☐ ☐ Angina	☐ ☐ Shortness of breath	☐ ☐ Constipation
☐ ☐ Hip disorders	☐ ☐ Numbness	☐ ☐ Excessive bruising	☐ ☐ Pneumonia	☐ ☐ Diarrhea
☐ ☐ Knee injuries	☐ None Initials:	☐ None Initials:	☐ None Initials:	☐ None Initials:
☐ ☐ Fool/ankle pain	**Sensory**	**Skin**	**Endocrine**	**Genitourinary**
☐ ☐ Shoulder problems	☐ ☐ Blurred vision	☐ ☐ Skin cancer	☐ ☐ Thyroid issues	☐ ☐ Kidney stones
☐ ☐ Elbow/wrist pain	☐ ☐ Ringing in ears	☐ ☐ Psoriasis	☐ ☐ Immune disorders	☐ ☐ Infertility
☐ ☐ TMJ issues	☐ ☐ Hearing loss	☐ ☐ Eczema	☐ ☐ Hypoglycemia	☐ ☐ Bedwetting
☐ ☐ Poor posture	☐ ☐ Chronic ear	☐ ☐ Acne	☐ ☐ Frequent infection	☐ ☐ Prostate issues
☐ None Initials:	☐ ☐ Loss of smell	☐ ☐ Hair loss	☐ ☐ Swollen glands	☐ ☐ Erectile dysfunction
	☐ ☐ Loss of taste	☐ ☐ Rash	☐ ☐ Low energy	☐ ☐ PMS symptomps
Constitutional	☐ None Initials:	☐ None Initials:	☐ None Initials:	☐ None Initials:
☐ ☐ Low libido	☐ ☐ Poor appetite	☐ ☐ Fatigue	☐ ☐ Sudden weight gain	☐ ☐ Sudden weight loss
☐ ☐ Weakness	☐ ☐ Fainting	☐ None Initials:		

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Illnesses

Mark the illnesses that you've **Had** in the past **Have** now. If none apply below check this box

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Polio	☐	☐	Typhoid fever
☐	☐	Alcoholism	☐	☐	Epilepsy	☐	☐	HIV positive	☐	☐	Rheumatic fever	☐	☐	Ulcer
☐	☐	Allergies	☐	☐	Glaucoma	☐	☐	Malaria	☐	☐	Scarlet fever	**Other Illnesses**		
☐	☐	Arteriosclerosis	☐	☐	Goiter	☐	☐	Measles	☐	☐	Sexually trans. disease	☐	☐	
☐	☐	Cancer	☐	☐	Gout	☐	☐	Multiple sclerosis	☐	☐	Stroke	☐	☐	
☐	☐	Chicken pox	☐	☐	Heart disease	☐	☐	Mumps	☐	☐	Tuberculosis	☐	☐	

Operations

Surgical interventions, which may or may not have included hospitalization. If none apply below check this box

☐ Appendix removal ☐ Cosmetic surgery ☐ Vasectomy

☐ Bypass surgery ☐ Tonsillectomy ☐ Hysterectomy

☐ Spine: ☐ Elective surgery: ☐ Pacemaker

☐ Cancer ☐ Eye surgery ☐ Other:

Treatments

Surgical interventions, which may or may not have included hospitalization. If none apply below check this box

Past	Currently		Past	Currently		Past	Currently		Past	Currently		Past	Currently	
☐	☐	Acupuncture	☐	☐	Blood transfusions	☐	☐	Dialysis	☐	☐	Hormone replacement	☐	☐	Physical therapy
☐	☐	Antibiotics	☐	☐	Chemotherapy	☐	☐	Herbs	☐	☐	Inhaler			
☐	☐	Birth control pills	☐	☐	Chiropractic care	☐	☐	Homeopathy	☐	☐	Massage therapy			

Allergies. Are you allergic to any medication? ☐ Yes ☐ No (if yes, please list)

Injuries

Have you ever... If none apply below check this box

☐ Had a fractured or broken bone ☐ Been knocked unconscious ☐ Used a crutch or other support ☐ Received a tattoo

☐ Had a spine or nerve disorder ☐ Been injured in an accident ☐ Used neck or back bracing ☐ Had a body piercing

Medications (Please list all prescriptions over-the-counter, natural supplements, enzymes, vitamins and minerals)

Past	Currently	Medication	Past	Currently	Medication	Past	Currently	Medication
☐	☐		☐	☐		☐	☐	
☐	☐		☐	☐		☐	☐	
☐	☐		☐	☐		☐	☐	

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Family History

Some health issues are hereditary. Tell Dr. LeMay about the health of your immediate family members

Relative	Age (if living)	State of health Good	State of health Poor	Illnesses	Age of death	Cause of death Natural	Cause of death Illness
Mother		☐	☐			☐	☐
Father		☐	☐			☐	☐
Sister 1		☐	☐			☐	☐
Sister 2		☐	☐			☐	☐
Brother 1		☐	☐			☐	☐
Brother 2		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

Are there any other hereditary health issues that you know about?

Social History

Tell Dr. LeMay about your health habits and stress levels.

Habit	Daily	Weekly	How much?
Alcohol use	☐	☐	
Coffee use	☐	☐	
Tobacco use	☐	☐	
Exercising	☐	☐	
Pain relievers	☐	☐	
Soft drinks	☐	☐	
Water intake	☐	☐	

Habit	Yes	No
Prayer or meditation?	☐	☐
Job pressure/stress?	☐	☐
Financial peace?	☐	☐
Vaccinated?	☐	☐
Mercury fillings?	☐	☐
Recreational drugs?	☐	☐

Hobbies:

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐

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Activities of Daily Living *(cont.)*

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

What is the major stressor in your life?

How much sleep do you average per night?

hours

What is the type and approx. age of your mattress and pillow?

What is your preferred sleeping position?

Describe your typical eating habits? ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

What would be the most significant thing that you could do to improve your health?

In addition to the main reason for your visit today, what additional health goals do you have?

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Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time. please read each statement and initial your agreement

Initials	Acknowledgment
	I understand and am informed that, as in the practice of medicine, in the practice of chiropractic or nutrition, there are material risks to treatment. "Material" shall be defined as a procedure inherently involving known risk of serious bodily harm. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I will rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. Chiropractic care is designed to reduce or correct vertebral subluxation. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.
	I have been verbally informed of the possible material risks involved in chiropractic care.
	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.
	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Dale of last menstrual period (MM/DD/YYYY):
	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, texts, emails or health information to me as an extension of my care in this office.
	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of all services I receive.
	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.
	I understand that Dr. Mark LeMay, D.C., A.C.N. may recommend nutritional products based upon his understanding and experience as a Nutritional Consultant. I also understand that these products/program is not intended as medical advice and does not replace the need for medical treatment and/or advice from my physician. I have been advised to consult with my physician prior to starting any supplementation or nutritional program.

Readiness Assessment

In order to improve your health, how willing are you to:

Significantly modify your diet	NOT WILLING	1	2	3	4	5	VERY WILLING
Take nutritional supplements each day	NOT WILLING	1	2	3	4	5	VERY WILLING
Keep a record of everything you eat each day	NOT WILLING	1	2	3	4	5	VERY WILLING
Modify your lifestyle (e.g. work demands, sleep habits)	NOT WILLING	1	2	3	4	5	VERY WILLING
Practice relaxation techniques	NOT WILLING	1	2	3	4	5	VERY WILLING
Engage in regular exercise	NOT WILLING	1	2	3	4	5	VERY WILLING
Have periodic lab tests to assess progress	NOT WILLING	1	2	3	4	5	VERY WILLING

Signature of Patient or Guardian (Entering name means signing document)

Date (MM/DD/YYYY)

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing.

Yours in Health,

Dr. Mark LeMay & Staff

Missed Appointment and Cancellation Policy

Our Mission is to assist you in strengthening and supporting your body. To help you go from symptoms controlling your life, to easily adapting to life's challenges.

We strive to provide our patients with the utmost professional and excellence of service. Our commitment to your well-being and enhancement of your health is taken very seriously by the doctor and members of this office.

Because we care so much about you we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimal results.

☐ **With the exception of a serious emergency, we expect you to keep all your appointments. If you need to re-schedule your appointment we require a 24 hour notice.**

☐ In the instance of a cancellation without a 24 hours notice or a no show to a scheduled appointment, **we reserve the right to charge you a $25 fee.**

☐ Arriving 10 minutes or more after your scheduled appointment qualifies as a missed appointment and **we reserve the right to charge you the $25 fee**. You will be asked to re-schedule your appointment to the next available time and/or day.

In an instance of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. If this were to happen, we will gladly refer you to another chiropractic office.

We appreciate you greatly as our patient and strive to accomplish the best result that we can for your health and well-being.

I _____ understand and agree to adhere to the missed appointment and cancellation policy.

_____ _____

Signature of Patient or Guardian (Entering name means signing document) Date (MM/DD/YYYY)

_____ _____

Office Staff Date (MM/DD/YYYY)