

# **Family Chiropractic Clinic Optimal Health Nutrition Center**

**Chiropractic and Nutritional Treatments**

Dr. Mark A. Pederson

Chiropractor & Clinical Nutritionist

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## **Patient Information Update Form:**

Greetings and thank you for contacting our office regarding your health concerns:

Enclosed you will find your information update form. Please complete in full and bring it with you to your scheduled appointment. Thank you.

**PATIENT INFORMATION:**

Title:  Dr.  Miss  Mr.  Mrs.  Ms.

First: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Sex:  Male  Female

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced

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

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

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

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

**PLEASE NOTE: In order to better serve you we utilize text messaging to remind you of your scheduled appointment.**

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone Carrier: \_\_\_\_\_

Does your plan include text messaging?  Yes  No

Does your plan include email messaging?  Yes  No

**PLEASE NOTE: In order to better serve you we utilize email messaging to remind you of your scheduled appointment.**

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

**Referred To Our Office By:** \_\_\_\_\_

Emergency contact information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

**Employment:**

Your employment status:

Employed  Employed Part-time  Retired  Part-time student  Full-time student

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

• Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

• City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

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

Type of Work:  Office/Clerical  Light labor  Moderate labor  Heavy labor

**INSURANCE INFORMATION:**

Has your insurance changed since your last visit?  Yes  No

Please bring your insurance card with you to your appointment.

Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscribers name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

SS #: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Group #: \_\_\_\_\_

**Assignment and Release:**

I certify that I, and/or my dependent(s) have insurance coverage with

\_\_\_\_\_  
(name of insurance company)

And assign directly to Dr. Mark Pederson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Mark Pederson may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of patient, parent, guardian or personal representative Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of patient, parent, guardian or personal representative Date \_\_\_\_\_

**PATIENT CONDITION:**

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

**Chief complaint #1 (reason you are here):**

1. \_\_\_\_\_

Previous treatment for this complaint? \_\_\_\_\_

When did your complaint first begin? \_\_\_\_\_

Have you ever experienced this complaint before? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

Describe the type of pain/symptom you experience? \_\_\_\_\_

\_\_\_\_\_

Does your problem travel into any other part of your body? Where? \_\_\_\_\_

Where exactly is the complaint area? \_\_\_\_\_

When do you notice the problem? \_\_\_\_\_

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)? \_\_\_\_\_

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? \_\_\_\_\_

**Other complaints or problems:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Current medications/drugs being taken:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Medical doctors or other health care professionals you have consulted with in the last 12 months?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Nutritional supplements you are taking:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Do you smoke, drink coffee or alcohol? (If yes indicate how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching  
△△△△

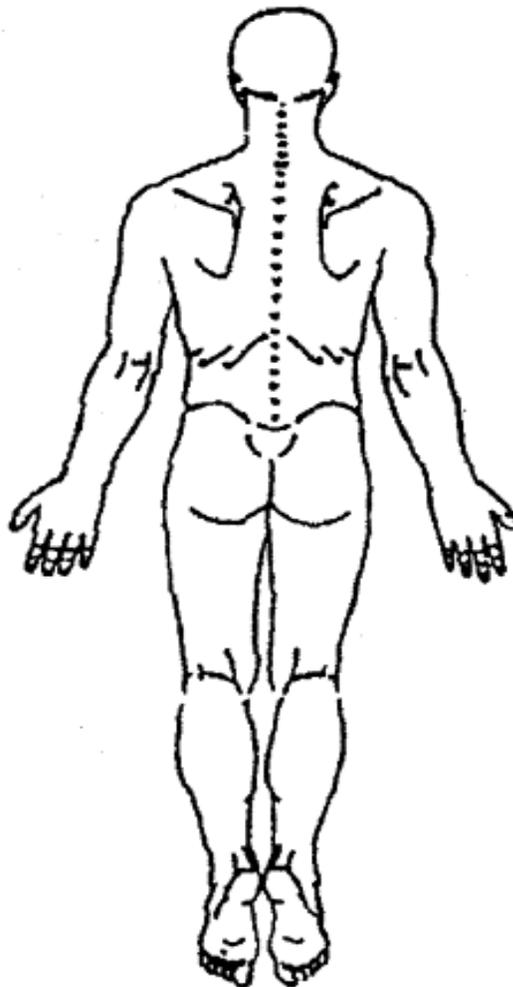
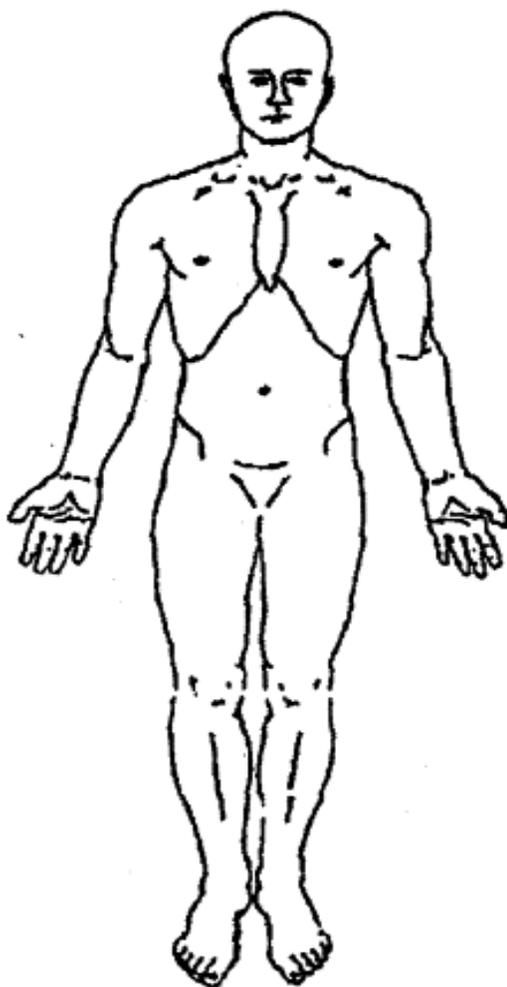
Numbness  
=====

Pins & Needles  
○○○○○

Burning  
XXX

Stabbing  
/////

Other  
.....



**Please check off the following that apply to you:**

<p><b>Digestive Track:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nausea and vomiting</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Bloating feeling</li> <li><input type="checkbox"/> Stomach pains/cramps</li> <li><input type="checkbox"/> Heart burn</li> <li><input type="checkbox"/> Blood/mucous in stools</li> </ul> <p><b>Ears:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Itchy ears</li> <li><input type="checkbox"/> Ear aches/ear infections</li> <li><input type="checkbox"/> Drainage from ears</li> <li><input type="checkbox"/> Ringing in the ears</li> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> Reddening of ears</li> </ul> <p><b>Emotions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mood swings</li> <li><input type="checkbox"/> Anxiety/fear/nervousness</li> <li><input type="checkbox"/> Argumentative</li> <li><input type="checkbox"/> Frustrated/cries easily</li> <li><input type="checkbox"/> Depression</li> </ul> <p><b>Eyes:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Watery/itchy eyes</li> <li><input type="checkbox"/> Red/swollen/eyelids</li> <li><input type="checkbox"/> Bags/dark circles under eyes</li> <li><input type="checkbox"/> Blurred or tunnel vision</li> </ul> <p><b>Head:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Faintness</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Insomnia/sleep disorder</li> <li><input type="checkbox"/> Facial flushing</li> </ul> <p><b>Heart:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Irregular/skipped heartbeat</li> <li><input type="checkbox"/> Rapid/pounding heartbeat</li> <li><input type="checkbox"/> Chest pain</li> </ul> <p><b>Joints:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain/ache in joints</li> <li><input type="checkbox"/> Arthritis/osteoarthritis</li> <li><input type="checkbox"/> Stiffness/limited movement</li> <li><input type="checkbox"/> Pain/aches in muscles</li> <li><input type="checkbox"/> Feeling weak/tired</li> <li><input type="checkbox"/> Swollen/tender joints</li> <li><input type="checkbox"/> Growing pains in joints</li> <li><input type="checkbox"/> Psoriatic/gouty arthritis</li> <li><input type="checkbox"/> Rheumatoid arthritis</li> </ul>	<p><b>Lungs:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest congestion</li> <li><input type="checkbox"/> Asthma/bronchitis</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Wheezing</li> </ul> <p><b>Mind:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Poor memory</li> <li><input type="checkbox"/> Difficulty completing projects</li> <li><input type="checkbox"/> Difficulty with mathematics</li> <li><input type="checkbox"/> Underachiever</li> <li><input type="checkbox"/> Poor/short attention span</li> <li><input type="checkbox"/> Confusion</li> <li><input type="checkbox"/> Easily distracted</li> <li><input type="checkbox"/> Difficulty making decisions</li> <li><input type="checkbox"/> Learning disabilities</li> </ul> <p><b>Mouth and Throat:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic coughing</li> <li><input type="checkbox"/> Gagging/clearing throat</li> <li><input type="checkbox"/> Sore throat/hoarse voice</li> <li><input type="checkbox"/> Swollen/discolored tongue</li> <li><input type="checkbox"/> Canker sores recurrent</li> <li><input type="checkbox"/> Itching on roof of mouth</li> </ul> <p><b>Nose:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stuffy nose</li> <li><input type="checkbox"/> Chronically red/inflamed nose</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Sneezing attacks</li> <li><input type="checkbox"/> Excessive mucous formation</li> </ul> <p><b>Skin:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acne</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Hives/rash/dry skin</li> <li><input type="checkbox"/> Hair loss</li> <li><input type="checkbox"/> Flushing/hot flashes</li> </ul> <p><b>Weight:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Binge eating/drinking</li> <li><input type="checkbox"/> Craving certain foods</li> <li><input type="checkbox"/> Excessive weight</li> <li><input type="checkbox"/> Compulsive eating</li> <li><input type="checkbox"/> Water retention</li> </ul>	<p><b>Genitourinary:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent illness</li> <li><input type="checkbox"/> Frequent/urgent urination</li> <li><input type="checkbox"/> Genital itch/discharge</li> <li><input type="checkbox"/> Anal itching</li> <li><input type="checkbox"/> Kidney problems</li> <li><input type="checkbox"/> Urinary tract infections</li> <li><input type="checkbox"/> Bladder problems</li> <li><input type="checkbox"/> Yeast infections</li> </ul> <p><b>Other Conditions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Autism</li> <li><input type="checkbox"/> ADD</li> <li><input type="checkbox"/> ADHD</li> <li><input type="checkbox"/> Psoriasis</li> <li><input type="checkbox"/> Eczema</li> <li><input type="checkbox"/> Auto immune disorder</li> <li><input type="checkbox"/> Chronic fatigue</li> <li><input type="checkbox"/> Multiple chemical sensitivities</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Congestive heart failure</li> <li><input type="checkbox"/> Severe diabetic</li> <li><input type="checkbox"/> Severe depression</li> <li><input type="checkbox"/> Obsessive compulsive disorder</li> </ul>
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## Family Chiropractic Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

**Chiropractic** is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is call a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

**Subluxations are corrected and/or reduced by an adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

**We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.** However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

**All questions regarding doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.** The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_

Print Name	Signature	Date
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\_\_\_\_\_  
Doctor's Signature

**Minors:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

**Females:**

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date