BASLER
FAMILY CHIROPRACTIC

PERSONAL INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)

PREFERRED NAME

ADDRESS

CITY STATE ZIP CODE

PHONE

EMAIL

SOCIAL SECURITY NUMBER BIRTHDAY AGE

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ OTHER ☐ MINOR

EMPLOYER/SCHOOL

OCCUPATION

SPOUSE'S NAME

SPOUSE'S EMPLOYER / OCCUPATION

IN CASE OF EMERGENCY, CONTACT

NAME RELATIONSHIP

CONTACT NUMBER

PREFERED FORM OF COMMUNICATION: ☐ TEXT ☐ EMAIL ☐ PHONE

Who may we thank for referring you?

HOW CAN WE SERVE YOU TODAY?

PLEASE CHECK THE TYPE OF CARE DESIRED SO THAT WE MAY BE GUIDED BY YOUR WISHES WHENEVER POSSIBLE.

☐ **RELIEF CARE**
Symptomatic relief of pain or discomfort

☐ **COMPREHENSIVE CARE**
Bring whatever is malfunctioning in the body to the highest state of health possible with specific Gonstead Chiropractic care.

☐ **CORRECTIVE CARE**
Correcting and relieving the cause of the problem as well as the symptoms

☐ **SUPPORTIVE CARE**
Keep the Central Nerve System properly adapting and functioning at 100%

Patient Number: _____ Date: _____

CONCERNS & IMPACT

BASLER
FAMILY CHIROPRACTIC

PRIMARY CONCERN

The primary concern that prompted me to seek care today is:

_____

_____

HOW OFTEN DOES THIS OCCUR?

☐ Constant ☐ Intermittent ☐ ___ % of the day

WHAT DOES IT FEEL LIKE?

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull
☐ Aching ☐ Cramping ☐ Nagging ☐ Sharp
☐ Shooting ☐ Burning ☐ Throbbing ☐ Stabbing
☐ Swelling ☐ Other _____

Does it radiate? If so, where? _____

AND IS THE RESULT OF:

☐ An accident or injury ☐ Work ☐ Auto
☐ A worsening long-term problem
☐ Other _____

ONSET DATE (When did you first notice your concern?)

_____

What aggravates the concern?

_____

What relieves the concern?

_____

If this concern went without being taken care of, how do you think it would affect you? _____

_____

SECONDARY CONCERN

The secondary concern that prompted me to seek care today:

_____

_____

HOW OFTEN DOES THIS OCCUR?

☐ Constant ☐ Intermittent ☐ ___% of the day

WHAT DOES IT FEEL LIKE?

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull
☐ Aching ☐ Cramping ☐ Nagging ☐ Sharp
☐ Shooting ☐ Burning ☐ Throbbing ☐ Stabbing
☐ Swelling ☐ Other _____

Does it radiate? If so, where? _____

AND IS THE RESULT OF:

☐ An accident or injury ☐ Work ☐ Auto
☐ A worsening long-term problem
☐ Other _____

ONSET DATE (When did you first notice your concern?)

_____

What aggravates the concern?

_____

What relieves the concern?

_____

If this concern went without being taken care of, how do you think it would affect you? _____

_____

ADDITIONAL CONCERN

The additional concern that prompted me to seek care today:

_____

_____

HOW OFTEN DOES THIS OCCUR?

☐ Constant ☐ Intermittent ☐ ___% of the day

WHAT DOES IT FEEL LIKE?

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull
☐ Aching ☐ Cramping ☐ Nagging ☐ Sharp
☐ Shooting ☐ Burning ☐ Throbbing ☐ Stabbing
☐ Swelling ☐ Other _____

Does it radiate? If so, where? _____

AND IS THE RESULT OF:

☐ An accident or injury ☐ Work ☐ Auto
☐ A worsening long-term problem
☐ Other _____

ONSET DATE (When did you first notice your concern?)

_____

What aggravates the concern?

_____

What relieves the concern?

_____

If this concern went without being taken care of, how do you think it would affect you? _____

_____

IMPACT OF YOUR SYMPTOMS

(How do these concerns currently interfere with your life and ability to function?)

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

	No Effect	Mild	Moderate	Severe
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐
Duties of employment	☐	☐	☐	☐

Patient Name: _____ **Patient Number:** _____ **Date:** _____

PATIENT HISTORY

BASLER
FAMILY CHIROPRACTIC

INJURIES & ILLNESS

HAVE YOU EVER...

☐ Had a fracture or broken bone
☐ Had a spine or nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
- If job related, have you made a report of your accident to your employer? ☐ No ☐ Yes

If yes, please explain _____

_____

Have you had COVID? ☐ No ☐ Yes

If yes, when/date(s) _____

Was it confirmed by a test? ☐ No ☐ Yes

If yes, when/date(s) _____

What were your symptoms? _____

_____

Have you received any COVID vaccine(s)? ☐ No ☐ Yes

If yes, which manufacturer? _____

when/date(s) _____

ILLNESS, PAST OPERATIONS & HOSPITALIZATIONS

_____

_____

_____

_____

_____

HEALTH HABITS

Alcohol	☐ Daily	☐ Weekly	How much? _____
Coffee	☐ Daily	☐ Weekly	How much? _____
Tobacco	☐ Daily	☐ Weekly	How much? _____
Exercise	☐ Daily	☐ Weekly	How much? _____
Pain relievers	☐ Daily	☐ Weekly	How much? _____
Soft drinks	☐ Daily	☐ Weekly	How much? _____

Vaccinated? ☐ Yes ☐ No

Mercury fillings? ☐ Yes ☐ No

Recreational drugs? ☐ Yes ☐ No

Do you wear heel/sole lifts or arch supports?
☐ Yes ☐ No

How much sleep do you average per night? _____ Hours

What is the type and approximate age of your mattress?

_____

What is your preferred sleeping position?

_____

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

ALLERGIES

_____

_____

MEDS, VITAMINS & SUPPLEMENTS

_____

_____

_____

STRESS LEVELS

Prayer or meditation? ☐ Yes ☐ No

_____

_____

Job pressure/stress? ☐ Yes ☐ No

_____

_____

Financial peace? ☐ Yes ☐ No

_____

_____

What is the major stressor in your life?

_____

_____

_____

_____

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

FOR WOMEN ONLY

How many children do you have? _____ Are you nursing? ☐ No ☐ Yes

Are you on birth control? ☐ No ☐ Yes

Do you have irregular cycles? ☐ No ☐ Yes

Do you experience painful periods? ☐ No ☐ Yes

Do you have breast implants? ☐ No ☐ Yes

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

OB/GYN / Midwife _____

Number of past pregnancies _____

Concerns / complications with this pregnancy? _____

_____

_____

☐ 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.

Date of last menstrual period (MM/DD/YYYY): _____ Initial here _____

Patient Name: _____ **Patient Number:** _____ **Date:** _____

REVIEW OF SYSTEMS

BASLER
FAMILY CHIROPRACTIC

Mark the circle beside any condition that you've had, currently have or have family history of.

MUSCULOSKELETAL

Osteoporosis	☐ Had	☐ Have	☐ Family History
Arthritis	☐ Had	☐ Have	☐ Family History
Scoliosis	☐ Had	☐ Have	☐ Family History
Neck pain	☐ Had	☐ Have	☐ Family History
Back problems	☐ Had	☐ Have	☐ Family History
Hip disorders	☐ Had	☐ Have	☐ Family History
Knee injuries	☐ Had	☐ Have	☐ Family History
Foot/ankle pain	☐ Had	☐ Have	☐ Family History
Shoulder problems	☐ Had	☐ Have	☐ Family History
Elbow/wrist pain	☐ Had	☐ Have	☐ Family History
TMJ issues	☐ Had	☐ Have	☐ Family History
Poor posture	☐ Had	☐ Have	☐ Family History

SKIN

Skin cancer	☐ Had	☐ Have	☐ Family History
Psoriasis	☐ Had	☐ Have	☐ Family History
Eczema	☐ Had	☐ Have	☐ Family History
Acne	☐ Had	☐ Have	☐ Family History
Hair loss	☐ Had	☐ Have	☐ Family History
Rash	☐ Had	☐ Have	☐ Family History

GENITOURINARY

Kidney stones	☐ Had	☐ Have	☐ Family History
Infertility	☐ Had	☐ Have	☐ Family History
Bedwetting	☐ Had	☐ Have	☐ Family History
Prostate issues	☐ Had	☐ Have	☐ Family History
Erectile dysfunction	☐ Had	☐ Have	☐ Family History
PMS symptoms	☐ Had	☐ Have	☐ Family History

SENSORY

Blurred vision	☐ Had	☐ Have	☐ Family History
Ringing in ears	☐ Had	☐ Have	☐ Family History
Hearing loss	☐ Had	☐ Have	☐ Family History
Chronic ear infection	☐ Had	☐ Have	☐ Family History
Loss of smell	☐ Had	☐ Have	☐ Family History
Loss of taste	☐ Had	☐ Have	☐ Family History

DIGESTIVE

Ulcer	☐ Had	☐ Have	☐ Family History
Food sensitivites	☐ Had	☐ Have	☐ Family History
Food allergies	☐ Had	☐ Have	☐ Family History
Heartburn	☐ Had	☐ Have	☐ Family History
Constipation	☐ Had	☐ Have	☐ Family History
Diarrhea	☐ Had	☐ Have	☐ Family History

CARDIOVASCULAR

High Blood Pressure	☐ Had	☐ Have	☐ Family History
Low Blood Pressure	☐ Had	☐ Have	☐ Family History
High Cholesterol	☐ Had	☐ Have	☐ Family History
Poor Circulation	☐ Had	☐ Have	☐ Family History
Angina	☐ Had	☐ Have	☐ Family History
Excessive bruising	☐ Had	☐ Have	☐ Family History

RESPIRATORY

Asthma	☐ Had	☐ Have	☐ Family History
Apnea	☐ Had	☐ Have	☐ Family History
Emphysema	☐ Had	☐ Have	☐ Family History
Hay fever	☐ Had	☐ Have	☐ Family History
Shortness of breath	☐ Had	☐ Have	☐ Family History
Pneumonia	☐ Had	☐ Have	☐ Family History

ENDOCRINE

Thyroid issues	☐ Had	☐ Have	☐ Family History
Immune disorders	☐ Had	☐ Have	☐ Family History
Hypoglycemia	☐ Had	☐ Have	☐ Family History
Frequent infection	☐ Had	☐ Have	☐ Family History
Swollen glands	☐ Had	☐ Have	☐ Family History
Low energy	☐ Had	☐ Have	☐ Family History

CONSTITUTIONAL

Fainting	☐ Had	☐ Have	☐ Family History
Low libido	☐ Had	☐ Have	☐ Family History
Poor appetite	☐ Had	☐ Have	☐ Family History
Fatique	☐ Had	☐ Have	☐ Family History
Sudden weight loss	☐ Had	☐ Have	☐ Family History
Sudden weight gain	☐ Had	☐ Have	☐ Family History
Weakness	☐ Had	☐ Have	☐ Family History

NEUROLOGICAL

Anxiety	☐ Had	☐ Have	☐ Family History
Depression	☐ Had	☐ Have	☐ Family History
Headache	☐ Had	☐ Have	☐ Family History
Dizziness	☐ Had	☐ Have	☐ Family History
Pins and needles	☐ Had	☐ Have	☐ Family History
Numbness	☐ Had	☐ Have	☐ Family History
Migraines	☐ Had	☐ Have	☐ Family History

Is there anything else you would like us to know about you or your family's health and overall goals?

Patient Name: _____ Patient Number: _____ Date: _____

ACKNOWLEDGMENTS

BASLER
FAMILY CHIROPRACTIC

OUR EXPERIENCE HAS SHOWN THAT IT IS BENEFICIAL TO HAVE A GREAT UNDERSTANDING WITH OUR CLIENTS AS TO WHAT GONSTEAD CHIROPRACTIC IS, THE VALUES OUR OFFICE HOLDS AND FEES FOR SERVICE. PLEASE READ EACH SECTION, INITIAL ALONG THE SIDE AND SIGN AND DATE AT THE BOTTOM.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the central nervous system - CNS) and how this relationship can affect the restoration and preservations of health. The Gonstead Chiropractor goes beyond by conducting a thorough analysis of your spine using five criteria to detect the presence of the vertebral subluxation complex. Spinal adjustments are performed to correct or reduce spinal joint (vertebral) subluxations. Vertebral subluxation is a disturbance to the CNS and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the CNS. The primary goal in chiropractic care is by application of a precise movement and/or the force into the spine to reduce and/or correct vertebral subluxation(s). There are several different methods or techniques by which the chiropractic adjustment is delivered, typically delivered by hand.

At Basler Family Chiropractic (BFC), we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/office will not be held responsible for any pre-existing medical conditions. 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. Initial here _____

While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic care, like other forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per million to one per two million, have been associated with chiropractic adjustments. Chiropractic is a separate and distinct healing art form and does not proclaim to cure any named disease or entity. We strive to provide you with the very best care and if the results are not acceptable, we will refer you to another provider who we feel can further assist you. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at BFC have been explained to me to my satisfaction and my initials convey my understanding of both. Initial here _____

PRIVACY POLICY

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open at times. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the setting used for taking patient histories, performing examinations, or presenting report of findings- these procedures are completed in a private confidential setting.

This office is required to notify you that by law, we must maintain the privacy and confidentiality of your personal health information. You may request a copy of the Privacy Policy and understand it describes how your personal health information is protected and released on your behalf for seeking reimbursement from any involved third parties. Initial here _____

Whom do you authorize we discuss your care with _____

VALUES

Our goal is to provide you with excellent customer service and care. To attain the level of achievement we both desire, care must be followed and therefore we need your commitment as well. We value your time and commitment and work diligently to serve you in a timely manner. Please keep your appointments as scheduled or call/text within 24 hours to request changes.

Patient Name: _____ **Patient Number:** _____ **Date:** _____

ACKNOWLEDGMENTS (CONTINUED)

BASLER
FAMILY CHIROPRACTIC

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of care in this office. Initial here _____

FEE FOR SERVICES

We offer several methods of payment for your care at our office, and you may choose the plan/method that you prefer. This information will enable us to serve you and help to avoid misunderstanding in the future. Our main concern is your health and well-being and we will do our best to help you!

IMPORTANT: All clients are responsible for full payment for first visit (unless other arrangements have been made in advance.) Please review the estimated fee worksheet provided as an estimate of your fees for service. Late payment may be subject to 18% annual finance charge which will be added monthly to your statement. I acknowledge that any insurance I have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. Initial here _____

In addition, we are just that - a FAMILY office - we have family pricing available with use of our discount medical network, Chiro-Health USA.

Thank you for the opportunity to serve you with specific Gonstead Chiropractic Care.

Signature _____ Date_____

Doctor's Signature _____ Date_____

CA initials _____

Patient Name: _____ Patient Number: _____ Date: _____