Los Gatos Chiropractic and Wellness Center

Name: ____ Date: _________________________

Address: ____

City: _______________________________ State:___________ Zip: ____________

Phone# Home: (___)______________________ Other: (___)_________________

Occupation: ____

Date of Birth: ______________ Age: _______Sex: Male/Female (please circle)

Marital Status: S M W D (Please Circle)

Name and Number of Person to Contact in Case of Emergency:

____

Referred By:

____

May we e-mail you with information about our office? Yes No e-mail address________________________

When, where and from whom did you last receive medical or health care? _______________________________
____

What are your most important health concerns? Please list from most to least important.

1.____ 4.____
2.____ 5.____
3.____ 6.____
Others: ____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU ARE INTERESTED IN:

Food Allergy Testing
Nutritional Testing
Testing For Depression
Anxiety or Mental Health
Detoxification Diet
Hormone Testing
Fertility Testing
Complete Cardiovascular Panel
Anti-aging/preventive medicine testing
Non-hormone Options for Birth control
Heavy Metal Testing
Wellness Screening
Gynecologic & Breast Exam
Digestive Analysis
Body Composition Analysis

PAST MEDICAL HISTORY

Have you ever been vaccinated? Yes No What childhood illnesses have you had?
Rubella (German 3 day measles) Measles (2 week) Mumps Chickenpox Whooping cough Polio
Rheumatic Fever Scarlet Fever Asthma Others _____________________________

FAMILY HISTORY: Please use the following chart to indicate any health disorders you or your family has had.

Condition:	You	Mom or her Siblings	Dad or his Siblings	Grandparent (indicate Mom or Dad's Side)	Siblings (indicate age and gender)	Your Children: Other (indicate)
Age now or age when deceased						
Allergies						
Alcoholism						
Anemia						
Arthritis						
Asthma						
Autoimmune Disease						
Benign Tumors						
Cancer (indicate type)						
Candida						
Celiac Disease						
Coronary Artery Disease						
Crohn's Disease						
Depression						
Digestive Complaints:						
Diabetes						
Eating Disorder						
Eczema						
Endometriosis/ Fibroids/Infertility						
Gout						
Heart Attack/Stroke						
Mental Disorder						
Thyroid Condition						
Ulcerative Colitis						
Genetic or Other Health Conditions:						

YOUR HEALTH HISTORY:

HOSPITALIZATIONS & SURGICAL PROCEEDURES: (list as best you can):

Type of illness or operation/procedure.	Date	Hospital
______________________________	______	______________
______________________________	______	______________
______________________________	______	______________
______________________________	______	______________

MEDICATIONS: List all the drugs, vitamins, and herbs you take, including dosages.

____
____
____
____

ALLERGIES:

Do you have any allergies (medicine, chemicals, outdoor, pets, foods, etc)? Yes No
If yes, please list: ____
What happens when you have an "allergy attack"? ______________________________
____
____

HEALTH HABITS:

Do you drink? Yes No How often?: wine______ beer________other alcohol_________________
Do you use tobacco or have you in the past? No Yes, how long? ______ How many? ______________
Total years since you have stopped smoking? ____________
Do you now or have you in the past used recreational drugs? Yes No
You may state which ones if you so choose ______________________________________
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins? Yes No
If yes, please explain.____
____
Do you exercise? Yes No What form(s)?____
How often?________________________________
Which of the following do you do regularly: Jogging Swimming Walking Biking Gardening Yoga Breathing Exercises Meditation Weightlifting Other________________________________
Have you traveled outside the U.S. in the past two yeas? No Yes, where? ________________

DIET:

How many meals do you generally eat each day? One Two Three More than three
Where do you usually buy your food? _______________Who cooks the food you eat?________________
Describe your typical breakfast, lunch, dinner and snacks per day_____________________________
____
____
____
____
Mark which of these you consume regularly. Coffee Caffeinated teas Highly seasoned foods Processed foods Preservatives Refined foods Soda Candy
How many cups of coffee tea or caffeinated drinks do you consume per day?______________________

List foods you eat which you suspect may be harmful to your health____________________________________

____

____

List any foods you crave (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.):

____

____

List any foods to which you have a bad reaction:____

____

Are you thirsty? Yes No Amount of water you drink each day:_______________________________

Are you satisfied with your diet as it is now? Yes No If no, why not?______________________________

____

GASTROINTESTINAL HEALTH:

How many bowel movements are you having per day?______Do you have a history of hemorrhoids? Yes No

Any recent change in bowel habits? Yes No If yes, please describe? ______________________________

Please mark any of the following that apply to your stool: blood mucus undigested food light color looks like rabbit pellets loose well formed normal stool other:_______________________________

SLEEP: - Do you have trouble falling asleep? Yes No If yes, what keeps you up? _____________________

____

Do you sleep straight through the night? Yes No Do you wake feeling refreshed? Yes No

Do you snore? Yes No Have you ever been tested for sleep apnea? Yes No

FEMALE REPRODUCTIVE HEALTH:

Have you ever used **birth control** pills? Yes No If yes, how long?______________________________

Side effects?____

Have you ever used an **I.U.D.**? Yes No How long?____________ What kind?______________________

Side effects?____

Age of first menstruation _______ Did you have a normal puberty? Yes No

Periods occur every _____ days. Regular? Yes No Periods usually last ______ days (average).

Date of last period ______________________________

Days of heavy _____ medium_____ light_______ bleeding during your cycle, days of spotting_________

Please mark **B** if before, **D** if during or **A** if after menstruation.

_______ Nervous tension	_______ Depression	_______ Headache	________Weight gain
_______ Irritability	_______ Forgetful	_______ Craving for sweets	________Bloating
_______ Mood changes	_______ Crying	_______ Increased appetite	________Extremity swelling
_______ Anxiety	_______ Confusion	_______ Heart pounding	________ Breast tenderness
_______ Insomnia	_______ Cramping	_______ Dizziness or fainting	________ Fatigue

Date of last **PAP** Smear ________ Was it normal? Yes No

Have you had in the past, or do you currently have problems with infertility? __________________________

______ # of pregnancies ______ # of births ______ # of miscarriages ______ # of abortions

Any complications of pregnancy? Yes No If yes, please explain. _________________________________

____

What age was you Mother when she started Menopause?_______________ Female Siblings?________________

Do you have a history of fibroids? Yes No or ovarian cysts? Yes No endometriosis? Yes No

Please check Y for Yes N for No and P for Past for any of the following health conditions:

GENERAL INFORMAITON:	Y	N	P	EYES:	Y	N	P
Recent Weight Gain/Loss				Wear Eye Glasses/Contacts			
Weakness				Double Vision			
Fatigue				Blurred Vision			
Fever				Loss of Vision			
Fainting				Eyes Sensitive to Light			
Nausea				Excessive Tearing			
Vomiting				Dry Eyes			
Balance Problems				**EARS:**	**Y**	**N**	**P**
Jaw Pain (TMJ)				Loss of Hearing			
Neck Pain				Ringing/Buzzing in Ears (Tinnitus			
Neck Stiffness				Ear Infections			
Shoulder Pain				Vertigo (Dizziness)			
Arm Pain				Any Discharge from Ears			
Wrist/Hand Pain				**NOSE:**	**Y**	**N**	**P**
Numbness Arms or Hands				Sinus Problems			
Upper Back Pain				Nosebleeds			
Lower Back Pain				Loss of Smell			
Hip Pain				Any Discharge from Nose			
Leg Pain				**MOUTH/THROAT:**	**Y**	**N**	**P**
Knee Pain				Tooth Pain			
Ankle/Foot Pain				Sores in Mouth, Lips or Gums			
Numbness Legs or Feet				Frequent Sore Throats			
Joint Swelling				Difficulty Swallowing			
Tension				Mercury Fillings			
Nervousness				**RESPIRATORY (LUNGS):**	**Y**	**N**	**P**
Anxiety				Difficulty Breathing			
Irritability				Chronic Cough			
Sleeping problems/Insomnia				Asthma			
Depression				Bronchitis			
Liver Problems				Emphysema			
Cancer				Tuberculosis or Pneumonia			
Metal Implants				Last Chest Radiograph			
Headaches				**CARDIO (HEART PROBLEMS):**	**Y**	**N**	**P**
Loss of Consciousness				Chest Pain			
Dizziness				Difficulty Breathing			
Memory Problems				Palpitations			
Seizures/Convulsions				Night Sweats			
				Cold Extremities			
				High Blood Pressure			
				Low Blood Pressure			
				Heart Murmur			
				Ever Have an ECG/EKG			

Please check Y for Yes N for No and P for Past for any of the following health conditions:

GI (GASTROINTESTINAL):	Y	N	P	GU (GENITOURINARY):			
Upset Stomach				**FEMALES:**	**Y**	**N**	**P**
Loss of Appetite				Pelvic Inflammatory Disease			
Indigestion				Urinary Tract Infections			
Constipation				Breast Cancer &/or Benign Tumors			
Diarrhea				Blood in Urine			
Bloody Stool				Painful Urination			
Abdominal Pain				Vaginal Discharge or Chronic Yeast			
Excessive Gas				Fibroids			
Loss of Bowel Control				Breast Tenderness			
Hemorrhoids				Hot Flashes			
Have You Had A Colonoscopy				Loss of Bladder Control			
ENDOCRINE:	**Y**	**N**	**P**	Currently Pregnant			
Cold or Heat Intolerance				Have you had a Pelvic Ultrasound			
Excessive Sweating				Have You Had A Mammogram			
Excessive Thirst or Hunger				**MALES:**	**Y**	**N**	**P**
Diabetes				Prostate Problems			
Thyroid Conditions				Hernias			
Kidney Conditions				Penile Discharge			
OTHER:	**Y**	**N**	**P**	Blood in Urine			
Currently Sexually Active				Painful Urination			
Currently Trying to Become Pregnant				Frequent Urination			
				Testicular Pain			
				Loss of Bladder Control			

The above information is true to the best of my knowledge.

Patient's Signature:

X__________________________ Date ________

Informed Consent & Office Policies

Our commitment here at the Los Gatos Chiropractic and Wellness Center is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interest it may be necessary to share information with other Health care Providers or Associates for the purpose of ordering laboratory analysis, payment, scheduling of your appointment or in the instance of a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released with the written authorization of the individual, as provided for by law.

Please be aware Health and Safety Code section 109250 et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation or cure of cancer. If you have been diagnosed with cancer we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. All payment is expected at the time of service. Debit cards, master card, visa, cash and check are acceptable forms of payment.

Please be advised that if you cannot keep your scheduled procedure or appointment for any reason, we request that you cancel the appointment with at least 24 hours prior. Failure to cancel within that time frame or no showing for the appointment will cost a fee of $50.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Kate Fox, D.C.

I have read and understand this form.

Signed: ____

Print Name: ____Date:_____________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

____
Print Patient's Name

____
Signature of Patient

____
Date Signed:

To be completed by patient's representative, if necessary, e.g. if patient is a minor or physically or legally incapacitate.

____
Print Name of Patient

____
Print Name of Patients Representative

____
Signature of Patients Representative

As:_______________________________
Relationship or Authority of Patients Representative

____
Date Signed

Name of Doctor treating this patient: **Dr. Kate Fox**