

HavaChiro at Huffman Chiropractic

1695 Mesquite Ave. #114 Lake Havasu City, AZ 86403 P (928) 412-8866

Rayce Meyers, D.C., FASBE

havachiro.com

Patient Name _____ Prefer to be called _____ Date _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Would you like text appointment reminders? Y/N _____ if yes Cell Carrier _____
Initial this box to Opt-in to accept text/SMS messages in accordance with HavaChiro's Privacy Policy

Email address _____ Do you want year end statements emailed? Y/N _____

Sex: M F Marital Status: M S D W Emergency Contact # _____

Date of Birth _____ Age _____ Current Weight _____ Height _____

Social Security # _____ Spouse's Name (if married) _____

Occupation _____ Employer _____

Who may we thank for your referral to our office today _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- Relief of a symptom or problem
- Relief and Prevention of a symptom or problem
- Healthier spine and nerve system
- Optimal health on all levels

1. Reasons for seeking chiropractic care Primary reason _____

Secondary reason _____

Other concerns _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s)

3. Past Health History

A. Please indicate if you have a history of any of the following

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
- Females only: Are you pregnant? Yes, ___ No ___ Breast Augmentation? Yes, ___ No ___ Date: _____
- None of the above

B. Previous Injury or Trauma

Patient Name _____ Date _____

Have you ever broken any bones? Which?

C. Allergies _____

D. Medications _____

Medication Reason for taking

E. Surgeries

Date Type of Surgery

4. Family Health History

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

Social and Occupational History

A. Job description

B. Work schedule

C. Recreational activities

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet)

Patient Name _____ Date _____

Review of Systems

*Have you had any of the following pulmonary (lung-related) issues?

- Asthma/difficulty breathing
COPD
Emphysema
Other
None of the above

*Have you had any of the following cardiovascular (heart-related) issues or procedures?

- Heart surgeries
Congestive heart failure
Murmurs or valvular disease
Heart attacks/MIs
Heart disease/problems
Hypertension
Pacemaker
Angina/chest pain
Irregular heartbeat
Other
None of the above

*Have you had any of the following neurological (nerve-related) issues?

- Visual changes/loss of vision
One-sided weakness of face or body
History of seizures
One-sided decreased feeling in the face or body
Headaches
Memory loss
Tremors
Vertigo
Loss of sense of smell
Strokes/TIAs
Other
None of the above

*Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?

- Thyroid disease
Hormone replacement therapy
Injectable steroid replacements
Diabetes
Other
None of the above

*Have you had any of the following renal (kidney-related) issues or procedures?

- Renal calculi/stones
Hematuria (blood in the urine)
Incontinence (can't control)
Bladder Infections
Difficulty urinating
Kidney disease
Dialysis
Other
None of the above

*Have you had any of the following gastroenterological (stomach-related) issues?

- Nausea
Difficulty swallowing
Ulcerative disease
Frequent abdominal pain
Hiatal hernia
Constipation
Pancreatic disease
Irritable bowel/colitis
Hepatitis or liver disease
Bloody or black tarry stools
Vomiting blood
Bowel incontinence
Gastroesophageal reflux/heartburn
Other
None of the above

*Have you had any of the following hematological (blood-related) issues?

- Anemia
Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
HIV positive
Abnormal bleeding/bruising
Sickle-cell anemia
Enlarged lymph nodes
Hemophilia
Hypercoagulation or deep venous thrombosis/history of blood clots
Anticoagulant therapy
Regular aspirin use
Other
None of the above

*Have you had any of the following dermatological (skin-related) issues?

- Significant burns
Significant rashes
Skin grafts
Psoriatic disorders
Other
None of the above

*Have you had any of the following musculoskeletal (bone/muscle-related) issues?

- Rheumatoid arthritis
Gout
Osteoarthritis
Broken bones
Spinal fracture
Spinal surgery
Joint surgery
Arthritis (unknown type)
Scoliosis
Metal implants
Other
None of the above

*Have you had any of the following psychological issues?

- Psychiatric diagnosis
Depression
Suicidal ideations
Bipolar disorder
Homicidal ideations
Schizophrenia
Psychiatric hospitalizations
Other
None of the above

*Is there anything else in your past medical history that you feel is important to your care here?

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. This healthcare building and individual offices are equipped with audio-visual surveillance, and this consent form serves as notice that I am aware of this technology at these premises for my protection. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between health care provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager.

Patient or Guardian Signature _____ Date: _____

Patient or Guardian Name Printed _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake, do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake, do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Patient Name _____ **Date** _____

Symptom 3 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake, do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake, do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Patient Name _____ Date _____

Symptom 5 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake, do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake, do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day