# Toensing Family Chiropractic

## PLEASE PRINT CLEARLY AND FILL IN COMPLETELY – FRONT AND BACK

**Name** _____ **Cell #:** _____ **Provider (Verizon, AT&T):** _____

**Street Address** _____ **Age:** _____

**City** _____ **State** _____ **Zip** _____ **Date of Birth** _____

❑ **Male** ❑ **Female** ❑ **Right Handed** ❑ **Left Handed** **E-Mail** _____

## Health History:

**I am here for:** ❑ **Wellness Care** ❑ **A Health Concern**

Problem area(s): _____ Work Related? ❑ Yes ❑ No

Date of onset: _____ ❑ Sudden ❑ Gradual Duration: ❑ min ❑ hours ❑ days ❑ months ❑ years

Pattern of problem: ❑ Constant ❑ Intermittent ❑ Occasional ❑ _____

Initiating Factors: _____

What makes it better? _____

What makes is worse? _____

List any current medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

## Personal & Family History:

Occupation: _____ Employer: _____

Marital Status: _____

Spouse's name and health status: _____

Children's names, ages and health status: _____

## Chiropractic History:

Have you ever been to a Chiropractor before? ❑ Yes ❑ No If yes: Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

## Wellness Commitment:

At Toensing Family Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for you cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Where did you hear about our office or who referred you? ❑ Friend _____

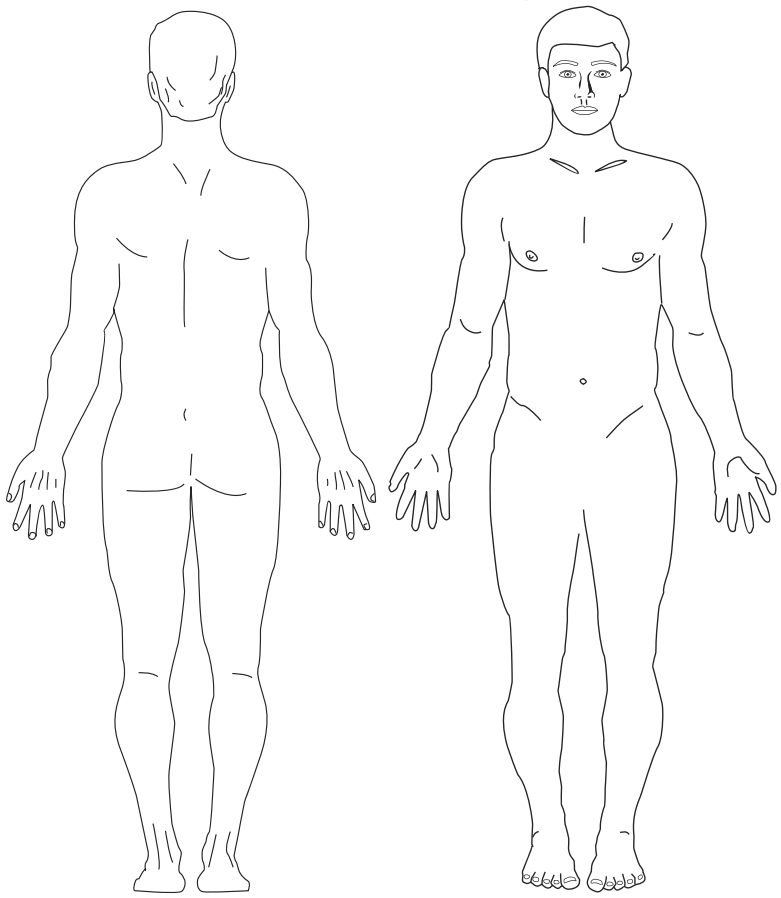
❑ Flyer ❑ Newspaper ❑ Radio ❑ Sign ❑ Other _____

# PLEASE FILL IN BELOW

**If you have had the following, or if you suffer from the following, *Please Check* ✔**

| Condition, Symptom Or Problem | Constantly or Frequently | Sometimes or Occasionally |
|---|---|---|
| Grating/Grinding Neck | ❑ | ❑ |
| Neck Pain | ❑ | ❑ |
| Shoulder Pain | ❑ | ❑ |
| Arm/Hand Pain | ❑ | ❑ |
| Mid Back Pain | ❑ | ❑ |
| Low Back Pain | ❑ | ❑ |
| Hip Pain | ❑ | ❑ |
| Leg/Foot Pain | ❑ | ❑ |
| Disc Problems | ❑ | ❑ |
| Arthritis | ❑ | ❑ |
| Other Joint Pain | ❑ | ❑ |
| Numbness | ❑ | ❑ |
| Cold Hands/Feet | ❑ | ❑ |
| Pins and Needles | ❑ | ❑ |
| Headache | ❑ | ❑ |
| Migraine | ❑ | ❑ |
| Dizziness | ❑ | ❑ |
| Ringing in Ears | ❑ | ❑ |
| Earaches | ❑ | ❑ |
| Hearing Loss | ❑ | ❑ |
| Sinus Trouble | ❑ | ❑ |
| Frequent Colds | ❑ | ❑ |
| Difficulty Breathing | ❑ | ❑ |
| Allergies | ❑ | ❑ |
| Asthma | ❑ | ❑ |
| Chronic Cough | ❑ | ❑ |
| Chest Pains | ❑ | ❑ |
| Heart Problems | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ |
| Low Blood Pressure | ❑ | ❑ |
| Digestive Problems | ❑ | ❑ |
| Urinary Problems | ❑ | ❑ |
| ADD/ADHD | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Cancer | ❑ | ❑ |
| Loss of Sleep | ❑ | ❑ |
| Faulty Posture | ❑ | ❑ |
| Painful Menstrual Cycles | ❑ | ❑ |
| Irregular Cycles | ❑ | ❑ |
| Pregnant At This Time | ❑ | ❑ |
| Other _____ | ❑ | ❑ |

**Circle the areas where you have any problems. Please also describe these problems.**



**Below, please fill in any other health information you feel we might need for your care.**

*Thank you for being complete and thorough.*

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## AUTHORIZATION

### CONSENT TO TREAT

I hereby authorize this office and its doctors to examine and administer care to me as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all these fees charged by this office for such care.

### HIPPA – NOTICE OF PRIVACY POLICIES

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or other healthcare operations. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPPA requirements, is available upon request.

### DISCLAIMER

Please be advised that the nutritional, chiropractic, herbal programs that are administered by our office, and/or Dr. Korey Toensing (chiropractor) are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also be advised that any and all testing ordered by our office and/or Dr. Korey Toensing, whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

Please sign to confirm that you have read and give consent to treat, that you have read and understand our privacy policies, and that you have read and understand our disclaimer.

Patient/Guardian Signature _____Date_____