Pomperaug Chiropractic
and Holistic Center, PC
3 Pomperaug Office Park, Suite 103
Southbury, CT 06488 (203) 264-3583

You ought not to attempt to cure
eyes without head, or head without body,
so you should not treat body without soul
- Socrates

Patient History

First Name_____ Last Name_____ Date_____

Address_____ City_____ State _____ Zip_____

Home Phone_____ Work phone _____ Cell_____ E-Mail_____

Date of Birth_____ Age_____ Social Security #_____

Occupation_____ Employer_____

Marital Status: □S □M □D □W Number of Children _____ Ages_____

Ethnicity_____ Race_____ Preferred Language_____

Referred By_____ and_____

Name of Emergency Contact_____ Phone #_____

Insurance

Insurance Co._____ Name of Insured_____
Date/Birth_____ ID # _____ Group #_____
Employer _____
Is your visit related to an accident: □ Automobile; □Work; Potential Legal Litigation?: □Y/□N

Chiropractic Treatment Consent
I hereby request and consent to integrative patient care at the Pomperaug Chiropractic & Holistic Center, PC including Chiropractic heath care. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks including, but not limited to, fractures, disk injuries, dislocations and strains 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 treatment concerning which treatment(s) are in my best interest, based upon the facts as they are then known.

Patient's Signature _____ **Date**_____
(Parent or guardian of minor)

Medical Release/Assignment of Benefits
I authorize Pomperaug Chiropractic & Holistic Center, PC to release any Protected Health Information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Pomperaug Chiropractic Center. I understand that I am fully responsible for any unpaid or unassigned portion of charges incurred at this office. ***Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility***.

□ ***I choose to decline receipt of my clinical summary after every visit.*** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient's Signature _____ **Date**_____
(Parent or guardian of minor)

General Health Information

Height____' ____" Weight_____ lbs. □ Left Handed □Right Handed
Do you consider your self: □ Underweight; □ Overweight □ Just right

Have you ever:	**Yes/No**	**Briefly Explain**
Had Chiropractic care?	□/□	
Had Naturopathic care?	□/□	
Had a Pacemaker?	□/□	
Broken Bones?	□/□	
Been Hospitalized?	□/□	
Had Surgery?	□/□	
Had other traumas or injuries?	□/□	

When was your last complete physical?_____ Blood Tests: □Y/□N X-rays: □Y/□N (body-part) _____
Other Tests (describe) _____ Results?_____
Who is your primary doctor?_____ Address_____ Phone_____
Date of last visit to primary doctor:_____ Reason for visit:_____

Family History -☑ all that apply

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Mother's Side	□	□	□	□	□	□
Father's Side	□	□	□	□	□	□

List any diseases or health conditions you now have, or have been treated for in the past. (Give a brief description):_____

_____

Reason for your visit today:

□ I am here for Wellness Care □ I am here for Lifestyle Change & Nutritional Counseling
□ I am here for treatment of pain, injury or condition, describe:_____

_____

□ Other:_____
When did this problem begin?_____ Cause of Onset:_____

Describe your Complaint: ☑ all that apply
□Sharp □Dull □Aching □Burning □Numbing □Shooting □Tightness □Throbbing □Diffuse □Tingling
Frequency of Complaint: □Continuous □Frequent □Intermittent □Occasional

Rate your symptoms on a scale from 0 – 10: (0=None, 10=Intolerable), please circle: **0 1 2 3 4 5 6 7 8 9 10**
Does your pain radiate or move? □Y/□N, If so, where?_____
What aggravates your condition/pain?_____
What relieves your condition/pain?_____
Is the condition worse at certain times of the day? □Y/□N, When?_____
What activities are limited due to your condition?_____
Is the condition getting progressively worse? □Y/□N_____
Previous doctors or treatments? _____
Any home remedies used?_____
Have you ever had same/similar condition before? □Y/□N, Explain:_____

Check any of the following symptoms, which you have now or have had in the past.

☐ Allergies	☐ Anemia	☐ Bruise Easily
☐ Cancer	☐ Constipation	☐ Diabetes
☐ Digestive Problems	☐ Frequent Urination	☐ Kidney stones
☐ Sciatica	☐ Antibiotic use in past 5 years	☐ Scoliosis/Spinal curvature
☐ Stroke	☐ Swollen Joints	☐ Ulcers
☐ Headaches	☐ Pins & Needles in Arms/Legs	☐ Cold Hands/Feet
☐ Neck Pain	☐ Numbness in Fingers/Toes	☐ Panic Attacks
☐ Back Pain	☐ Feeling of Anxiety	☐ Stomach upset/Ulcers
☐ Chest Pain	☐ Irregular Heart Rate	☐ Irritable bowel/Colitis
☐ Neck Stiff	☐ Shortness of Breath/Asthma	☐ Leg/feet cramps at night
☐ Ears Ring/Buzz	☐ Tension/Irritability	☐ Unexplained Fever
☐ Sleeping Difficulties	☐ High Blood Pressure	☐ Eczema/Skin Rashes
☐ Clench/Grind Teeth	☐ Cold Sores/Fever Blisters	☐ Severe Menstrual Cramps
☐ Dizziness/Vertigo	☐ Depression/S.A.D.	☐ Chronic Fatigue
☐ Roving muscle/joint Pain	☐ Alcoholism/Addictions	☐ Eyes very sensitive to light
☐ Recent unexplained weight loss	☐ Recent change in bowel or bladder function	☐ PTSD
☐ Dental Problems	☐ Other_____	

About Holistic Health Care

As represented by our logo, the body, mind and spirit are interconnected components of whole health. One's optimum health potential will be reached only when a "balance" exists between these three components. Pain and disease are often "symptoms" which result from imbalance in our lives. This form will aid us in discovering symptoms and "dis-ease" which may be related to imbalances in your life. Be assured that immediate referral will be made with the discovery of any disease or symptom which necessitates more immediate and specialized medical care. Those who are in need of more specialized medical intervention will often benefit from the addition of holistic chiropractic health care.

The Body

Lifestyle Factors: (☑)	**More than 3X's/day**	**3X's/day**	**2X's/day**	**Daily**	**Weekly**	**Occasional**	**Never**	**In Past but No Longer**
Alcohol	☐	☐	☐	☐	☐	☐	☐	☐
Caffeinated beverages	☐	☐	☐	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐	☐	☐	☐
Difficulty going to sleep☐ or Staying asleep☐				☐	☐	☐	☐	☐
Sleep less then 7 hours per night				☐	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐	☐	☐	☐
Sugary/Starchy Foods	☐	☐	☐	☐	☐	☐	☐	☐
Processed Foods	☐	☐	☐	☐	☐	☐	☐	☐
Home made Foods	☐	☐	☐	☐	☐	☐	☐	☐
Fruits & Vegetables	☐	☐	☐	☐	☐	☐	☐	☐
Red meats	☐	☐	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐	☐	☐
Dairy	☐	☐	☐	☐	☐	☐	☐	☐
How often do you eat out?	☐	☐	☐	☐	☐	☐	☐	☐

Exercise:

I Exercise: □Daily □2-3X's /wk □4-6X's /wk □1X/wk □ < 1X /wk □ Rarely □ Never
Describe the type of exercise that you do:_____

_____

List your Prescriptive or non-prescriptive drugs along with the dosage and reason for taking:_____

_____

_____

Do you have any allergies to Prescriptive or non-prescriptive drugs? If so list.:_____

_____

List your vitamins or natural remedies: _____

_____

_____

The Mind

Do you often feel rushed? □Y/□N_____
Do you easily lose your train of thought? □Y/□N_____
Is it difficult to shut off or slow your thoughts? □Y/□N_____
Is it difficult to motivate yourself? □Y/□N_____
Do you see a connection between your symptoms and your Emotional state/stress? □Y/□N_____
Do your symptoms change or go away while on vacation, away from home, or while distracted? □Y/□N_____

_____

Would you describe yourself as: (☑ all that apply)
□Hard on myself □Laid Back □Thorough or Meticulous □Highly responsible for others □Emotional
□Sensitive □Relaxed □Easily Startled □A worrier □Fearful □Highly Conscientious □Calm □Caretaker

Rate the level of stress you are experiencing on a scale of 0-10 (0 being no stress): **0 1 2 3 4 5 6 7 8 9 10**
What do you perceive as the source of your stress? (e.g., work, family, finances, legal, self, etc.)_____

_____

The Spirit

	Yes/No	Explain
Do you consider yourself spiritual?	□/□	_____
Do you feel a strong sense of purpose?	□/□	_____
Are you satisfied with your life?	□/□	_____
Do you pray or meditate regularly?	□/□	_____

Life Events - Check any of the following that have occurred within the last 3 years

□ Death of a Loved One	□ Divorce/Separation	□ Marriage/Family Additions
□ Job/Career Change	□ Personal injury/illness	□ Illness of a Loved One
□ Change of Residence	□ Change in Financial Status	□ A Difficult Relationship
□ Starting/Finishing School	□ Child Leaving Home	□ Business Difficulties

□ Other_____

List any major life events, (good or bad), which you anticipate within the next year:_____

_____

What are your current health Goals?_____