

# Welcome to Gengler Chiropractic

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Children's names \_\_\_\_\_  
Who may we "Thank" for your referral? \_\_\_\_\_ E-mail address: \_\_\_\_\_

The patient is responsible for all charges on the first day or as arranged with a financial agreement.

## Your Confidential Health Profile

### MAJOR COMPLAINT

How long have you had this condition \_\_\_\_\_ Date Began: \_\_\_\_\_  
Have you lost work days: Yes ( ) No ( ) When, how many? \_\_\_\_\_  
Have you had a similar condition before? Yes ( ) No ( ) When? \_\_\_\_\_  
Was the injury related to: work accident ( ) auto accident ( )  
When did you last see a chiropractor? \_\_\_\_\_ Dr. \_\_\_\_\_  
Why did you see this chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_  
What spinal maintenance programs were you given to follow to maximize the future stability of your spine? \_\_\_\_\_  
Did you follow it? \_\_\_\_\_ If not, why? \_\_\_\_\_  
Why are you changing chiropractors? \_\_\_\_\_

### Past (O) or Present (X) complaints

<input type="checkbox"/> Fractured bones	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Auto accidents	<input type="checkbox"/> Mistake sidedness (right from left)	<input type="checkbox"/> Heart problems
<input type="checkbox"/> 0-12 months ago	<input type="checkbox"/> Stutter	<input type="checkbox"/> Stroke
<input type="checkbox"/> 1-5 years ago	<input type="checkbox"/> Dylexia	<input type="checkbox"/> High or Low Blood pressure
<input type="checkbox"/> More than 5 years ago	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Other accidents or falls	<input type="checkbox"/> Lose Temper easily	<input type="checkbox"/> Liver trouble
<input type="checkbox"/> Knocked unconscious	<input type="checkbox"/> Headache	<input type="checkbox"/> Gall Bladder trouble
<input type="checkbox"/> Back curvature	<input type="checkbox"/> Neck pain or stiff R or L	<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Mental or Emotional disorders	<input type="checkbox"/> Numbness, tingling or pain in arms	<input type="checkbox"/> Excess Gas
<input type="checkbox"/> Arthritis	<input type="checkbox"/> hands or fingers R or L	<input type="checkbox"/> Belching/bloating after meals
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw pain or TMJ click R or L	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Swollen painful joints	<input type="checkbox"/> Head seems heavy	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Head and Shoulder feel tired	<input type="checkbox"/> Diarrhea/constipation
<input type="checkbox"/> Skin problems	<input type="checkbox"/> Difficulty in excess (standing, walking,	<input type="checkbox"/> Colon trouble
<input type="checkbox"/> Itching	<input type="checkbox"/> sitting, riding, bending,	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> lifting, twisting, household chores)	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Shoulder pain R or L	<input type="checkbox"/> Impotence
<input type="checkbox"/> Frequent Colds/Flus	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pain during martial relations
<input type="checkbox"/> Nervous	<input type="checkbox"/> Ringing in the ears R or L	<input type="checkbox"/> Kidney trouble
<input type="checkbox"/> Tension	<input type="checkbox"/> Hearing loss R or L	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Depressed	<input type="checkbox"/> Fainting	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Irritable	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Discharge
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blurred or double vision R or L	<input type="checkbox"/> Menstrual problems
<input type="checkbox"/> Excess sweating	<input type="checkbox"/> Upper back pain or stiffness R or L	<input type="checkbox"/> Breast lumps, soreness,
<input type="checkbox"/> Tremors	<input type="checkbox"/> Mid back pain or stiffness R or L	<input type="checkbox"/> discharge
<input type="checkbox"/> Light bothers eyes	<input type="checkbox"/> Lower back pain or stiffness R or L	<input type="checkbox"/> Pregnant (now)
<input type="checkbox"/> Allergy	<input type="checkbox"/> Numbness, tingling or pain in buttocks,	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> thighs, legs, feet, toes) R or L	<input type="checkbox"/> Ear infections
<input type="checkbox"/> Light headed upon rising	<input type="checkbox"/> Pain with cough, sneeze or strain at stools	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Under stress	<input type="checkbox"/> Hip pain R or L	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Crave sweets or salts	<input type="checkbox"/> Foot trouble R or L	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Chest pain	_____
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Lung problems	_____
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Difficult breathing	_____

**WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)** \_\_\_\_\_

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

\_\_\_\_\_ Temporary relief (Help the current symptoms but do not fix the cause of the problem)  
\_\_\_\_\_ Maximum correction (Correct the cause of the problem for maximum stability in the future)

**WHY DID YOU COME INTO OUR CLINIC, AND WHAT ARE YOUR EXPECTATIONS OF US?**

- 1. What are your favorite activities or hobbies you do now? \_\_\_\_\_
- 2. Are your current problems effecting these activities or hobbies? \_\_\_\_\_
- 3. What activities are you looking forward to in retirement? \_\_\_\_\_
- 4. Who would you like to be doing these activities with? \_\_\_\_\_

**On a scale of 1-10 (10 being the most)**

\_\_\_\_\_ How commited are you at being at your maximum health potential?  
\_\_\_\_\_ How important is it for your family to be at their maximum health potential?  
\_\_\_\_\_ How commited are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

List any vitamins/suppliments you are taking \_\_\_\_\_

Name other doctors you have seen for your health problems: What was done, and for how long?  
\_\_\_\_\_

Are you currently wearing: Heel Lifts ( ) Arch Supports ( )

I understand that all records established by this office are the sole property of Gengler Chiropractic. Copies may be obtained within 3 business days with proper medical release. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payments when services are rendered. I also understand that if I suspend or terminate care, any fees for services rendered to me will be due and payable immediatly. Any fee's in the collection of a debt such as late fees, collection fees, and/or attorney fees shall be paid by me. I have received a copy of the Notice of Protected Health Information, and Office policy sheet. I can request changes to these policies in writing. My signature below will serve as a signature on file. The statements on this form are accurate to the best of my recollection.

I hereby give Gengler Chiropractic consent to examine/treat me or my minor child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_