DEYOUNG CHIROPRACTIC

Patient Acct ____________

Legal Name ______________________________ DoB __________ Age ______ Today's Date _____________

Nickname _______________________ Phone Number __________________ Cell Carrier _________________

Email Address ____ Preferred Method of Contact: ☐Call ☐Text ☐Email

Street _______________________________________ City ___________________ Zip Code _____________

SSN _______________________ Marital Status ☐M ☐S ☐D ☐W Hobbies/Interests ________________________

Occupation _____________________ Employer ______________________________ ☐FT ☐PT ☐Retired ☐N/A

Number of Children and ages _______________________ Name of Spouse/Partner _________________________

Emergency Contact __________________________________ Phone Number ___________________________

Previous Chiropractic Care ☐Y ☐N If yes, explain ____

Current Height __________ Current Weight __________ Previous Surgery _______________________________

Current Medications ____

Current Vitamins ____

How did you hear about our office? ____

ABOUT YOUR HEALTH: The human body is designed to be healthy. Throughout life, trauma can occur which interes with your full health expresion. This case history will uncover the layers of damage to your spine and nervous system. Following your exam, we will outline a course of care to correct these layers of damage to recover your inborn health potential.

LOSS OF WELLNESS

1. Your Own Birth Process

☐Y ☐N Was the delivery long? ____
☐Y ☐N Was the delivery difficult? ____
☐Y ☐N Forceps? ____
☐Y ☐N Breech / Cephalic? ____
☐Y ☐N Home Birth? ____
☐Y ☐N Hospital Birth? ____
☐Y ☐N Mother given drugs during delivery? ____
☐Y ☐N Was labor induced? ____

2. Growth & Development

☐Y ☐N Were you taught to care for your spine? ____
☐Y ☐N Did you fall out of bed? ____
☐Y ☐N Were you breast fed? ____
☐Y ☐N Did you have childhood sickness? ____
☐Y ☐N Did you have childhood accidents? ____
☐Y ☐N Did you have surgery during childhood? ____
☐Y ☐N Did you take medicine during childhood? ____
☐Y ☐N Were you spanked or yanked as a child? ____
☐Y ☐N Were you physically abused? ____
☐Y ☐N Did you have any sports injuries as a child? ____
☐Y ☐N Were you a gymnast/cheerleader? ____
☐Y ☐N Other Traumas? ____

3. Current Health Habits

☐Y ☐N Did you or do you smoke? ____
☐Y ☐N Did you or do you drink alcohol? ____
☐Y ☐N Diet - Do you eat healthy foods? ____
☐Y ☐N Do you have problems sleeping? ____
☐Y ☐N Do you have any mental stress? ____
☐Y ☐N Do you have any physical stress? ____
☐Y ☐N Do you exercise? ____
☐Y ☐N Do you use a computer/tablet/phone? Duration? ____
☐Y ☐N Have you been in any car accidents? How many and when? _______________________________
☐Y ☐N Have you had any sports injuries? ____
☐Y ☐N Other traumas? ____

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Currently Pregnant: ☐Y ☐N ☐Unsure *If yes,* how many weeks? _______________ Due Date: _________________

Symptoms and Poor Health (Present state of Health)

Current health complaints/reasons for consulting our office: ____

____

Date when problem started _______________ Pains are ☐Achy ☐Dull ☐Sharp ☐Stabbing ☐Tingling and Numbness

Frequency of pain ☐Constant ☐ Come and go Is the condition worse during ☐AM ☐PM ☐Remain the same ☐______

What aggravates your condition? ____

What lessens your condition? ____

Does your condition interfere with your daily activities such as:

☐Sleep ☐Work ☐Sitting ☐Standing ☐Walking ☐Dressing ☐Physical Activity ☐Lifting >10lbs ☐Household Chores ☐Hobbies

Have you seen other doctors for this condition? ______________________ Any home remedies? _______________

Rate your pain based on 0 being NO PAIN and 10 being THE WORST PAIN:

Your pain right now _____ Your typical/average pain _____ Your pain at it's best _____ Your pain at it's worst ______

OTHER SYMPTOMS	☐NECK PAIN	☐MID BACK PAIN	☐LOW BACK PAIN
☐ADD/ ADHD	☐Vision Problems	☐Gallbladder Conditions	☐Menstrual Issues
☐Anxiety	☐Fatigue/ Trouble Sleeping	☐Stomach Problems	☐Reproductive Issues
☐Depression	☐Frequent Colds	☐Ulcers	☐Infertility
☐Irritability	☐Hearing Problems	☐Gastritis	☐Leg Numbness ☐R ☐L
☐Nervousness	☐Hand/Finger Numbness	☐Kidney Problems	☐Knee Pain ☐R ☐L
☐Difficulty Concentrating	☐Radiating Arm Pain ☐R ☐L	☐Indigestion	☐Hip Pain ☐R ☐L
☐Dizziness	☐Shoulder Pain ☐R ☐L	☐Constipation	☐Rib Pain
☐Vertigo	☐High Blood Pressure	☐Colitis	☐Scoliosis
☐Ringing in Ears	☐Heart Condition	☐Diarrhea	☐Carpal Tunnel
☐Asthma	☐Difficulty Breathing	☐Gas Pain	☐Thyroid Condition
☐Sinus Problems	☐Congestion	☐Irritable Bowel / IBS	☐Cancer ____________
☐Allergies	☐Bronchitis / Pneumonia	☐Bladder Issues	☐Other _____________

FAMILY HISTORY

☐Heart Disease / Attack - Relation ______________________________

☐Osteo / Rheumatoid Arthritis - Relation ______________________________

☐Diabetes I / II - Relation ______________________________

☐Cancer / Tumor - Relation ______________________________

☐Other ______________________________ Relation ______________________________

What prompted you to seek care? What is your goal?

☐Reduce symptoms / pain

☐Improve range of motion

☐Pain management

☐Prevent injury during exercise

☐Wellness

☐Improve body function

☐Find a solution to the ongoing issues

☐Return to regular activities/hobbies like ______________________________

Please check the options that apply to you:

☐I am only interested in short-term symptom relief care.

☐I am interested in symptom relief care & corrective care to maintain spinal stability & optimal nerve function

☐I feel good. I want to include chiropractic care into my wellness regimen so I can stay active for life.

☐I would like to schedule an appointment for my family members for a spinal check to ensure proper growth and development throughout all stages of life.

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

Signature of Patient ______________________________ Date ____________________

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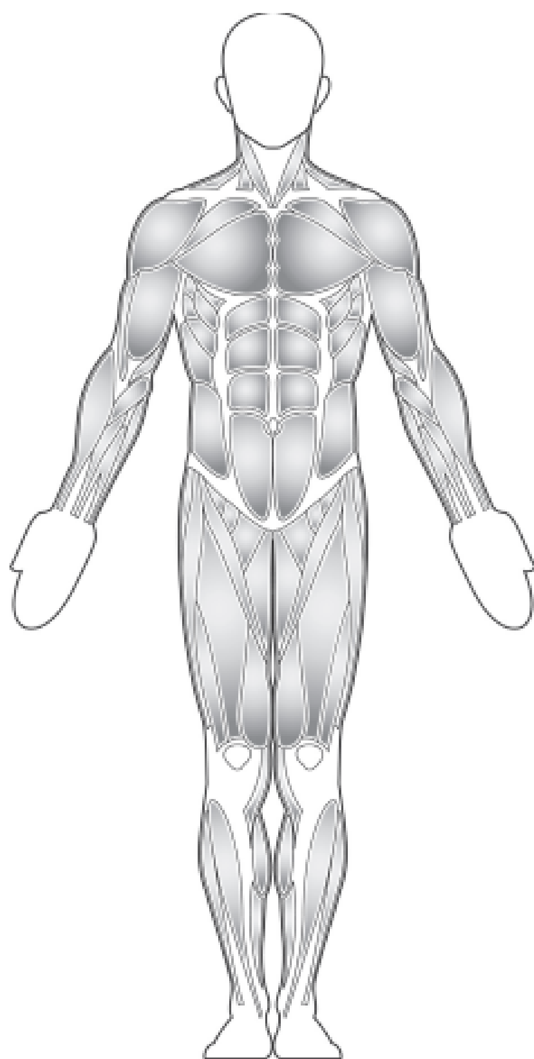
CONSULTATION FORM *PAIN ASSESSMENT*

Patient Name: ________________________________Date:________________________________

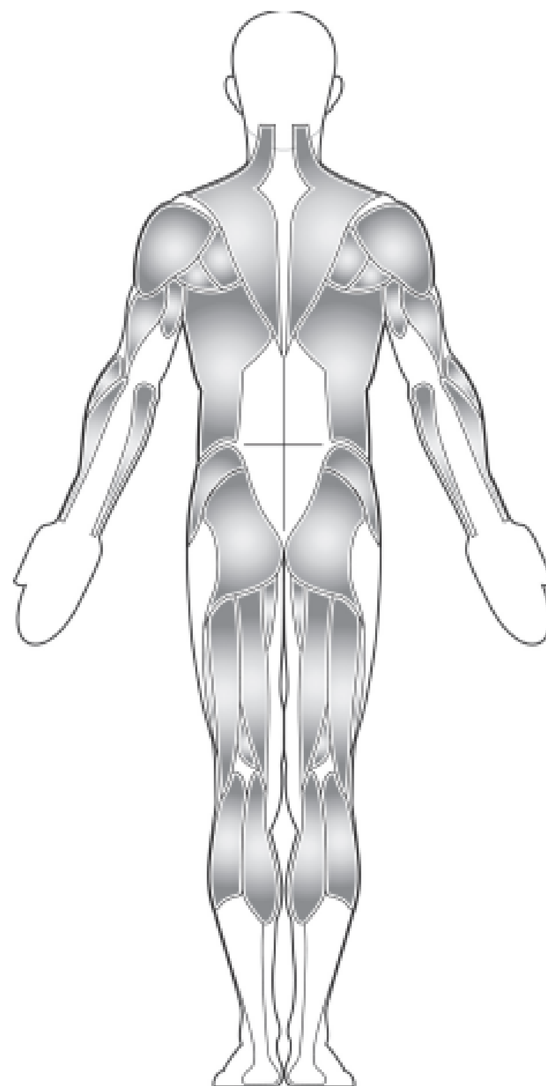
POSITIVE EFFECTS OF LASER THERAPY	BENEFITS TO PATIENT
• Improves and Promotes Healing • Reduces Pain and Spasm • Increases Joint Flexibility • Improves Peripheral Microcirculation • Detoxifies and Eliminates Trigger Points • Advanced Pain Relief	• Faster Patient Satisfaction • Deep Penetration Delivers More Laser Energy to the Target Tissues • Faster Treatment Times • Effective Treatment in 3-8 Minutes • Faster Patient Recovery Time



COLOR CHART

RED pen = Primary Pain

BLUE pen = Secondary Pain



Notes

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INFORMED CONSENT FOR INFRARED LASER THERAPY

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor.

Patient Signature: ____ Date:______________

Printed Name: ____ DoB: __________________

Employee Witness: ____ Date: ________________

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CONSULTATION FORM

COMMONLY ASKED QUESTIONS

How should I dress for a laser treatment?

Your laser treatment must be delivered directly to your skin. Wear clothing that will allow access to the area. Shorts, sweat pants, a sport bra or similar items are suggested.

How many treatment sessions will I need?

The number of laser therapy sessions you will need depends on the nature and duration of your condition, and other factors. Some acute conditions will respond in 6 or fewer sessions, whereas chronic conditions may take 15 or more treatments. Some chronic conditions require ongoing care to sustain pain relief and functionality.

What does it feel like to get a treatment?

Most patients describe it as a very soothing, warm sensation. Since the laser is a high-powered therapy laser, your skin will get warm during the treatment. Many patients feel a significant reduction in pain on the first visit. Occasionally, patients will feel slightly more pain immediately after the treatment – and then feel much better the next day.

How will I feel after the treatment?

You may feel pain relief after just the first treatment. For other patients, it takes a while longer. Most patients report feeling very relaxed, or even tired. If you feel a lot less pain, keep in mind that pain reduction is just one goal. The laser is giving your body's cells more energy so they repair and regenerate new tissues. The e ect of laser therapy treatments is cumulative. You will be getting more benefit with successive treatments.

Do I need to take special precautions after my laser treatment?

For the most part, no. Obviously you do not want to overexert and reinjure yourself. You may need to make changes in your work station. If you are planning to work out, you may want to reduce the intensity, or change the nature of your exercise. Discuss this with your doctor.

Should I use ice or pain relief gel after my laser treatment?

One effect of the laser treatment is vasodilation – which means your blood and lymphatic vessels have a larger diameter. This helps with inflammation reduction, but for some people the vasodilation can also make them sore. Use ice on the area, as directed by your doctor. You could use a pain relief gel, such as MyoMed.

I feel a lot better – but I still have sessions remaining in the laser treatment package I bought. What should I do?

Pain relief is just one goal in your care. Laser treatments help your body's repair and regeneration processes. Completing your laser therapy session package will further assist the healing processes. We suggest that you use all the treatments in the package, to ensure the most e ective care possible.

Why do I have to wear safety glasses during my laser treatment?

The laser is a high-powered therapy laser. Laser light can be focused by the lens of your eye, and potentially cause damage to your retina. The safety glasses you wear specifically block out the wavelengths of light produced by the laser.