

PATIENT HISTORY

1. Describe your complaints and symptoms causing you to seek treatment:
2. When did your condition begin, and what caused it to begin?
3. Has it been constant or off/on since it began? How frequent is the pain?
4. Is it getting worse, staying the same or getting better?
5. On a scale of 1-10 (with 10 being the most intense), how intense is your pain?
6. Is there anything you are unable to do because of the pain? (i.e. walk, dress, climb stairs, sit, etc.)
7. Does anything make your chief complaint worse?
8. Does anything make your chief complaint better?
9. What have you done on your own to alleviate your pain?
10. Is your condition work-related or due to a motor vehicle accident? If so, what date?

Muscular System

- frequent or severe headache
- headache with nausea
- muscular pain
 - neck
 - mid back
 - low back
 - shoulder Left/Right
 - arm Left/ Right
 - buttock Left/ Right
 - groin Left/ Right
 - thigh Left/ Right
 - leg/calf Left/ Right
- muscle spasms
 - neck
 - mid back
 - low back
 - pelvis
 - abdomen
- muscle weakness:
Location:

- other muscle disorder:

Gastrointestinal System

- nausea
- vomiting
- diarrhea
- difficulty swallowing
- pain from front to back
- indigestion
- constipation
- history of IBS
- abdominal pain
- bloody stool
- other disorder of GI:

Skeletal System

- spinal pain
 - neck
 - mid back
 - low back
 - pelvis
- joint or bone pain
 - jaw Left/ Right
 - shoulder Left/ Right
 - arm Left/ Right
 - elbow Left/ Right
 - forearm Left/ Right
 - wrist Left/ Right
 - hands Left/ Right
 - fingers Left/ Right
 - hip Left/ Right
 - thigh Left/ Right
 - knee Left/ Right
 - shin Left/ Right
 - ankle Left/ Right
 - foot Left/ Right
 - toes Left/ Right
- osteoarthritis
- rheumatoid arthritis
- gout
- other arthritis or bone disorder:

- other skeletal pain:

Endocrine System

- diabetes
- hyperactive thyroid
- hypoactive thyroid
- pancreatic disease
- hyperactive parathyroid
- hypoactive parathyroid
- adrenal disorder
- pituitary disorder

Nervous System

- ringing in ears
- difficulty speaking
- dizziness/vertigo
- loss of memory
- loss of coordination
- Areas of numbness:
 - arm Left/ Right
 - hand/fingers Left/ Right
 - buttock Left/ Right
 - thigh Left/ Right
 - leg Left/ Right
 - foot/toes Left/ Right
 - other areas of numbness:

- Areas of radiating pain:
 - arm Left/ Right
 - forearm Left/ Right
 - hand/fingers Left/ Right
 - buttock Left/ Right
 - thigh Left/ Right
 - leg Left/ Right
 - foot/toes Left/ Right

Cardiovascular System

- irregular heart beat
- swelling in legs
- purple nail beds
- current chest pain
- congestive heart disease
- open heart surgery
- rapid heart beat
- previous heart attack
- previous stroke
- high blood pressure
- history of TIA
- fainting
- vascular disease

Urinary System

- urgency to urinate
- loss of control
- difficulty starting urination
- decreased output, can't void
- increased output/frequency
- blood in urine
- recent bladder infection
- history of kidney stone

Reproductive System

- # of full term pregnancies: _____
- endometriosis
 - back spasm during menses
 - other disorder:
-
-

Respiratory System

- sore throat
 - cough
 - seasonal allergies
 - other allergy
 - asthma
 - emphysema
 - pain upon inhalation
 - dry cough
 - productive cough
 - chronic cough
 - coughing up blood
 - shortness of breath
 - tuberculosis
 - other disorder:
-
-
-

Integumentary System (Skin, Hair, Nails)

- eczema
 - psoriasis
 - clubbing of finger nails
 - fungal infection
 - bruising due to coumadin
 - trauma to skin
(cut, scrape, bruise):
-
-

Lymphatic System

- swollen lymph node
 - areas of swelling
 - injury to spleen
 - history of blood infection
 - sweating at night time
 - other blood disorder:
-

Special Senses

- blurred vision
- double vision
- visual disturbance
- loss of smell
- hearing loss
- loss of taste
- chronic ear infection

Surgical History

Date & Surgery:

General Health

- fever
 - unexplained weight loss
 - history of:
 - depression
 - fatigue
 - anxiety
 - history of cancer
Type and treatment:
-
-

- AIDS
 - anemia
 - multiple sclerosis
 - herpes
 - epilepsy
 - Parkinson's disease
 - other disease:
-
-

Social History

Occupation:

- job stress
- family stress
- smoke tobacco
- other tobacco use
- married
- children #: _____
- widowed

NAME _____ DATE _____ AGE _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.

- | NO | YES | ? | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a past history of cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any recent, unexplained, sudden or dramatic weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failure to respond to a course of conservative care (4-6 weeks)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had spinal pain greater than 4 weeks? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged use of corticosteroids? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current or recent urinary tract, respiratory tract or other infection? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any history of previous significant trauma? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has your pain developed for unexplained reasons, without episode of injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have osteoporosis (weak bones due to loss of bone density)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acute onset urinary retention or overflow incontinence (wet underwear) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of anal sphincter tone or fecal incontinence (bowel accidents) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Saddle anesthesia (numbness in the groin region) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Global or progressive muscle weakness in the legs (legs give out) |

COMMENTS: _____

Consent for Chiropractic Treatment

Benefits are expected from chiropractic treatment. Adverse events are highly unlikely and treatment should not cause adverse effects. Short-lived, minor discomforts may occur on occasion.

Risks of spinal manipulation (as documented in the medical/chiropractic publications):

- 1) The most common risks include short-term discomfort in the area of treatment, stiffness, headache, and fatigue.
- 2) Vascular Accident/Stroke – It is speculated that pre-existing weaknesses in the blood vessels of the neck and spine predispose patients to greater risk. If you suspect you are having a stroke, or have had a stroke, manipulation of the cervical spine should be avoided. I agree to inform the doctor of any such history.
- 3) Disc Herniation – Should a pre-existing disc bulge be on the verge of rupturing, the patient is a greater risk of adverse effects due to manipulation, and there is potential for adverse effects including disc rupture.
- 4) Patients with blood-clotting disorders and those taking anticoagulant (blood-thinning) drugs such as warfarin (Coumadin) are at increased risk of side effects such as spinal bleeding after manipulative therapy.
- 5) Patients with osteomyelitis (bone infection), cancer involving bone, prior vertebral fractures, severe degenerative joint disease (osteoarthritis), osteoporosis and ankylosing spondylitis are at greater risk to bone fracture.

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible).

I understand and am informed that there are some risks to chiropractic treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I understand the content of this consent form and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. If I should experience any adverse reactions to treatment I will immediately inform Dr. Murphy or any designee.

Print Patient Name: _____

Patient/Guardian Signature _____ **Date** _____



Infrared Phototherapy

Infrared Phototherapy is a physical treatment modality using a low-level laser and/or NASA superluminescent diodes in the infrared, near infrared and visible red light spectrum in order to stimulate a cascade of clinical benefits. The desired benefits include a temporary increase in local blood circulation, temporary relief of minor muscle and joint aches/pains and stiffness, relaxation of muscles, reduction of muscle spasms and reduction of minor pain and stiffness associated with arthritis.

If you would like to be considered as a candidate for phototherapy, please read and sign the following:

Treatment Steps

Target tissue needs to be exposed to the skin.

The patient will need to be clean and without oils or lotions on the skin in the area of application.

Unless the patient is laying face down, protective goggles will need to be worn by doctor and patient while low-level laser is in use.

The following tissues should not be treated with infrared phototherapy:

1. Eyes
2. Uterus during pregnancy
3. Suspicious lesion or cancer
4. A hyperactive thyroid gland
5. Site of injected steroid or injected medication within 3 weeks time

Please inform the doctor:

1. If you have a history of cancer.
2. If you are pregnant.
3. If you have a hyperactive thyroid.
4. If you have had a recent steroid or medication injection.

I have read the following and acknowledge that I do not have a history of cancer, am not pregnant, do not have a hyperactive thyroid and have not had a recent injection. I will inform the doctor prior to treatment if any of these criteria should change in the future.

Patient Signature _____

Date _____