

# Robert Townsend, Chiropractor

## Personal Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Marital Status: M S D W

Spouses/ Significant Other: \_\_\_\_\_ # of Children: \_\_\_\_\_

Name of Parents if minor: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

In Case of Emergency Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Whom may we thank for referring you to your office: \_\_\_\_\_

Method of Payment for Initial Visit:  Cash  Check  Visa  Master Card

### HEALTH INFORMATION

Purpose of this appointment: \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

When did this condition begin?: \_\_\_\_\_ Is it related to:  Job  Auto  Home

Are you taking medication now?: \_\_\_\_\_

Are you pregnant:  Yes  No If so, when is your due date?: \_\_\_\_\_

List surgical operations: \_\_\_\_\_

**IMPORTANT INFORMATION**...All events which could have any impact upon the spine are important to determine spinal health history. Please fill out completely.

### ACCIDENT / FALL HISTORY: (such as auto/ work/ sport-related/ jolts/ trauma/etc.)

Within the past year: \_\_\_\_\_

Over a year ago: \_\_\_\_\_

Childhood: \_\_\_\_\_

Hospitalizations; (other than above): \_\_\_\_\_

Previous Chiropractic Care:  No  Yes: Where/ When?: \_\_\_\_\_

## ACTIVITY LEVEL / MISC HEALTH INFO

Exercise:  None  Moderate  Daily  Heavy  
Work Activity:  Sitting  Standing  Light Labor  Heavy Labor  
Habits:  Smoking  Alcohol  Coffee/Caffeine Drinks  High Stress Level

Please check any of the following that give you difficulty or you have had recently

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches 784.0              | <input type="checkbox"/> Shoulder/ arm pain 719.4   | <input type="checkbox"/> Indigestion                  |
| <input type="checkbox"/> Shooting head pains 784.0    | <input type="checkbox"/> Pins. Needles in hands 782 | <input type="checkbox"/> Intestinal gas 787.3         |
| <input type="checkbox"/> Sinus trouble 473.9          | <input type="checkbox"/> Cold hands 782             | <input type="checkbox"/> Low back pain 724.2          |
| <input type="checkbox"/> Loss of smell 781.1          | <input type="checkbox"/> Numbness arms/ hands 782   | <input type="checkbox"/> Hernia 550.1                 |
| <input type="checkbox"/> Allergies 995.3              | <input type="checkbox"/> Tonsillitis 784            | <input type="checkbox"/> Stroke 436.0                 |
| <input type="checkbox"/> Hay fever 477.8              | <input type="checkbox"/> Prostate trouble 601.4     | <input type="checkbox"/> Arthritis 716.96             |
| <input type="checkbox"/> Asthma 493.9                 | <input type="checkbox"/> Bed wetting 788.3          | <input type="checkbox"/> Facial twitch 781.0          |
| <input type="checkbox"/> Loss of taste 781.1          | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Numbness in legs/feet 782    |
| <input type="checkbox"/> Throat inflammation 462      | <input type="checkbox"/> Shortness of breath        | <input type="checkbox"/> Constipation 564.0           |
| <input type="checkbox"/> Thyroid trouble 246.9        | <input type="checkbox"/> Mid-back pain              | <input type="checkbox"/> Kidney trouble 593.9         |
| <input type="checkbox"/> Twitching of face 361.9      | <input type="checkbox"/> Heart attacks 410.9        | <input type="checkbox"/> Menstrual cramps 625.3       |
| <input type="checkbox"/> Loss of Memory               | <input type="checkbox"/> Low blood pressure 458.9   | <input type="checkbox"/> Menstrual irregularity 626.4 |
| <input type="checkbox"/> Fatigue 780.4                | <input type="checkbox"/> High blood pressure 401.9  | <input type="checkbox"/> Diabetes 250.                |
| <input type="checkbox"/> Depression 311.0             | <input type="checkbox"/> Anemia 285.9               | <input type="checkbox"/> Sleeping problems 780.5      |
| <input type="checkbox"/> Dizziness 780.4              | <input type="checkbox"/> Stomach trouble 789        | <input type="checkbox"/> Painful joints 719.4         |
| <input type="checkbox"/> Spinal curvature 737.43      | <input type="checkbox"/> Nervousness 799.2          | <input type="checkbox"/> Swollen joints 719.0         |
| <input type="checkbox"/> Chest pain 786.5             | <input type="checkbox"/> Inner tension 799.2        | <input type="checkbox"/> Pins and needles in legs 782 |
| <input type="checkbox"/> Earache                      | <input type="checkbox"/> Irritability 799.2         | <input type="checkbox"/> Swollen ankles 782.3         |
| <input type="checkbox"/> Fainting 780.2               | <input type="checkbox"/> Gall bladder trouble 575.9 | <input type="checkbox"/> Cold feet 782                |
| <input type="checkbox"/> Loss of balance 781.2        |   | <input type="checkbox"/> Pain in legs/ feet 719.46    |
| <input type="checkbox"/> Ringing in ears 388.3        |   | <input type="checkbox"/> Hip pain 719.45              |
| <input type="checkbox"/> Blurred vision 368.0         |   | <input type="checkbox"/> Facial pain 784.0            |
| <input type="checkbox"/> Light bothers eyes 368.13    |   | <input type="checkbox"/> Jaw pain (TMJ) 525.9         |
| <input type="checkbox"/> Neck pain 723.1              |   | <input type="checkbox"/> Ulcers 534.9                 |
| <input type="checkbox"/> Muscle spasms in neck 719.68 |   | <input type="checkbox"/> ADD/ ADHD                    |
| <input type="checkbox"/> Grinding in neck 719.68      |   |   |
| <input type="checkbox"/> Shoulder tightness 728       |   |   |

## ADIO FAMILY CHIROPRACTIC'S TERMS OF ACCEPTANCE

When a person seeks Chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal; to detect and correct/ reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method is by specific adjustments of the spine.

**HEALTH:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spinal column which caused alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

**We do not offer to diagnose or treat disease or conditions other than vertebral subluxation.**

Regardless of what disease is called we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

**Note:** it is understood and agreed the amount paid to ADIO Family Chiropractor for x-ray is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient is in the office.

---

**CONSENT TO CARE**

I do hereby authorize the doctors of ADIO Family Chiropractor to administer such care that is necessary for my particular case. This care may include consultation, examination, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, \_\_\_\_\_, have read, understand and Hereby request Chiropractic care based on the above agreement.

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

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

Signature of parent or guardian if minor: \_\_\_\_\_