

Case # _____

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

An understanding of your health history will help us to determine appropriate care.

FULL NAME _____ DATE _____

AGE _____ RACE _____ GENDER _____ HEIGHT _____ WEIGHT _____

Review of Systems

1. Do you have skin, hair or nail problems? Yes No _____
2. Do you have mouth and/or throat problems? Yes No _____
3. Do you have nose and/or sinus problems? Yes No _____
4. Do you have ear problems? Yes No _____
5. Do you have eye problems? Yes No _____
6. Do you have chest or lung (breathing) problems? Yes No _____
7. Do you smoke? Yes No Amount per day _____ How Long? _____
8. Do you have heart and/or blood vessel problems? Yes No _____
9. Do you have blood or lymph node problems? Yes No _____
10. Do you have digestive problems? Yes No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? Yes No _____
12. Do you have urinary (including kidney or bladder) problems? Yes No _____
13. **Females**, have you had menstrual problems? Yes No _____
Have you ever taken birth control pills? Yes No For how long? _____
Is there any chance that you are currently pregnant? Yes No
Do you have any breast problems? Yes No _____
14. Do you have any nervous system diseases and/or mental health problems? Yes No _____
15. Do you have any gland and/or hormone problems? Yes No _____
16. Do you have allergy or immunity problems? Yes No _____
17. Do you have any muscle, tendon or ligament problems? Yes No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? Yes No _____

Past History

19. List any diseases which you have had in the past, including childhood diseases: _____

20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: _____

21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No

22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

(OVER PLEASE)

Case # _____

CASE HISTORY (CONTINUED)

FULL NAME _____

DATE _____

23. Have you ever been hospitalized for any reason other than surgery? Yes No _____

24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____

25. Your diet is: Balanced Fair Poor Excessive Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? Yes No _____

Social History

27. In what position do you usually sleep, and how well? _____

28. Do you exercise on a regular basis? Yes No How? _____

29. How do you spend your spare time (hobbies, etc)? _____

30. Do you use: Caffeine? Tobacco? Nicotine? Recreational Drugs? Alcohol?

31. Please describe your work.

Type: Professional Physical Labor Driver Clerical Factory Homemaker

Physical Demands: Heavy Moderate Mild Sedentary

Stress Level: High Medium Low

Additional Questions

32. Do you have problems with recurring headaches? Yes No _____

33. Are you losing weight without trying? Yes No

34. Does your pain wake you up at night? Yes No

35. Have you had a change in bowel or bladder habits? Yes No _____

36. Have you had a sore that doesn't heal? Yes No _____

37. Have you recently had any unusual bleeding or discharge? Yes No _____

38. Do you have a thickening/lump in the breast or elsewhere? Yes No _____

39. Do you have indigestion or difficulty swallowing? Yes No _____

40. Have you had an obvious change in a wart or mole? Yes No _____

41. Do you have a nagging cough or hoarseness? Yes No _____

42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

43. Please describe your current complaint. In other words, what brought you here? _____

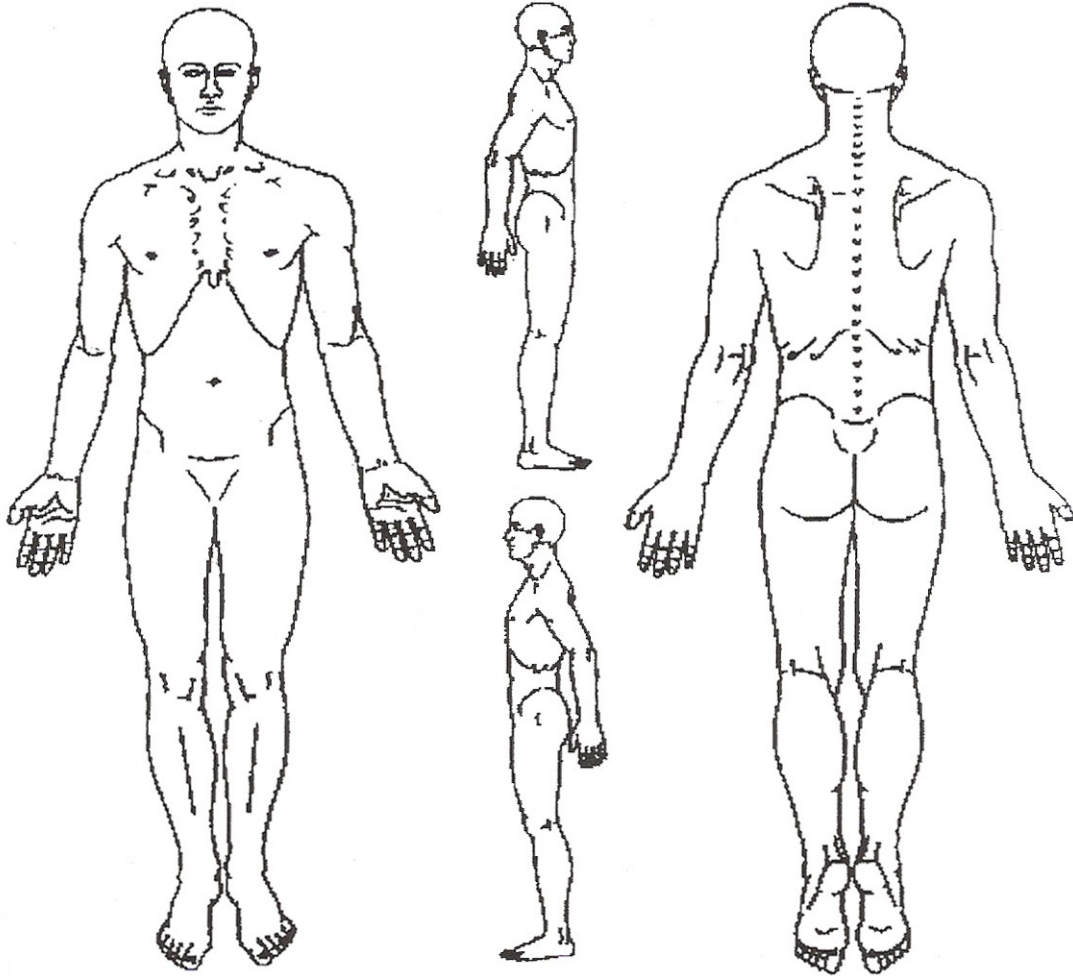
44. Who is your:

Medical Doctor? _____

OB/GYN? _____

Dentist? _____

Apex Health and Wellness
5110 South Florida Ave. Ste.103
Lakeland, FL 33813



A= ACHE
P= PINS & NEEDLES

B= BURNING
S= STABBING

N= NUMBNESS
O= OTHER

Apex Health and Wellness

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Apex Health Solutions
Robert Blackburn, D.C.
5110 South Florida Ave
Lakeland, FL 33813
813-816-5864

PATIENT NAME _____

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

➤ **The nature of the chiropractic adjustment**

I will use my hands upon your body in such a way as to move your joints. That may cause an audible "pop or click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

➤ **The material risks inherent in chiropractic adjustment**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

➤ **The probability of those risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during exam and X-ray. Stroke has been the subject of tremendous disagreement with the profession with one prominent authority (1) saying that there is as most of a one-in-a million chance of such an outcome. Since even risk should be avoided if possible, we employ tests in our exam which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Please check the appropriate block and sign below:

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment. I have discussed it with Dr. Robert Blackburn and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATE

PRINTED NAME

WITNESS SIGNATURE

PATIENT SIGNATURE