MARTELL CHIROPRACTIC AND ACUPUNCTURE CENTER
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CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date:_____ **Patient Chart Number:**_____

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Best # to Call: (Circle one) Home Cell Work Text Do Not Leave Messages

Home Phone: (_____) _____-_____ Email: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date of Birth: _____/_____/_____ Gender: Male Female Age:_____

Social Security Number: _____ - _____ - _____ Marital Status: M S W D

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer Information

Employer _____

Occupation _____

Spouse or Parent Information

First Name _____ Middle Initial _____ Last Name _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Primary Care Provider's Name _____

Whom may we thank for referring you? _____

Medical Conditions: (Check all that apply to you)

( ) Arthritis ( ) Cancer ( ) Diabetes ( ) Heart Disease

Since your symptoms began is it: ( ) Better ( ) Same ( ) Worse
Is your condition: ( ) Constant(100%) ( ) Frequent(75%) ( ) Intermittant(50%) ( ) Occasional(25%)
Is it worse in the: ( ) Am ( ) During The Day ( ) Pm ( ) Late Night?
Describe the pain / condition:
( ) Dull ( ) Ache ( ) Sharp ( ) Stabbing ( ) Tingling ( ) Burning ( ) Numbness ( ) Radiating Pain
( ) Spasm Other: _____
What makes it worse?
( ) Sit ( )Stand ( )Walk ( )Lying ( )Bend ( )Lift ( )Twist ( )Overuse Other: _____
What makes it better?
( ) Ice ( ) Heat ( ) Rest ( ) Stretch ( ) Exercise ( ) OTC Meds Other: _____

SECOND COMPLAINT _____
When and how did it occur:_____
Since your symptoms began is it: ( ) Better ( ) Same ( ) Worse
Is your condition: ( ) Constant(100%) ( ) Frequent(75%) ( ) Intermittant(50%) ( ) Occasional(25%)
Is it worse in the: ( ) Am ( ) During The Day ( ) Pm ( ) Late Night?
Describe the pain / condition:
( ) Dull ( ) Ache ( ) Sharp ( ) Stabbing ( ) Tingling ( ) Burning ( ) Numbness ( ) Radiating Pain
( ) Spasm Other: _____
What makes it worse?
( ) Sit ( )Stand ( )Walk ( )Lying ( )Bend ( )Lift ( )Twist ( )Overuse Other: _____
What makes it better?
( ) Ice ( ) Heat ( ) Rest ( ) Stretch ( ) Exercise ( ) OTC Meds Other: _____

THIRD COMPLAINT _____
When and how did it occur:_____
Since your symptoms began is it: ( ) Better ( ) Same ( ) Worse
Is your condition: ( ) Constant(100%) ( ) Frequent(75%) ( ) Intermittant(50%) ( ) Occasional(25%)
Is it worse in the: ( ) Am ( ) During The Day ( ) Pm ( ) Late Night?
Describe the pain / condition:
( ) Dull ( ) Ache ( ) Sharp ( ) Stabbing ( ) Tingling ( ) Burning ( ) Numbness ( ) Radiating Pain
( ) Spasm Other: _____
What makes it worse?
( ) Sit ( )Stand ( )Walk ( )Lying ( )Bend ( )Lift ( )Twist ( )Overuse Other: _____
What makes it better?
( ) Ice ( ) Heat ( ) Rest ( ) Stretch ( ) Exercise ( ) OTC Meds Other: _____

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, rate how you feel today

Primary Complaint:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Second Complaint:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Third Complaint:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Have you been treated for this condition (s) before? ( ) Yes ( ) No
If yes, by whom? _____
How long ago? _____ What treatment received?_____
Did it help? ( ) Yes ( ) No

( ) Hypertension ( ) Psychiatric Illness ( ) Skin Disorder ( ) Osteoporosis
( ) Stroke ( ) Fibromyalgia ( ) Asthma

Other: _____

Surgeries: (Check all that apply to you)

( ) Appendectomy ( ) Cardiovascular procedure ( ) Cervical spine ( ) Hysterectomy
( ) Heart ( ) Prostate ( ) Lumbar spine ( ) Gall Bladder
( ) Brain ( ) Shoulder ( ) Thoracic spine ( ) Uro-genital
( ) Hernia ( ) Carpal Tunnel ( ) Gastro-intestinal
( ) Breast Augmentation ( ) Joint Replacement

Other:_____

Allergies: (Check all that apply to you)

( ) Mold ( ) Seasonal ( ) Milk or Lactose ( ) Animal
( ) Chemical Sulfites ( ) Wheat/Glutens ( ) Eggs ( ) Soy
( ) Fish and Shellfish

Other: _____

Social History: (Check all that apply to you)

Caffeine use:	( ) Occasional	( ) Often	( ) Never
Drink Alcohol:	( ) Occasional	( ) Often	( ) Never
Exercise:	( ) Occasional	( ) Often	( ) Never
Chew Tobacco:	( ) Occasional	( ) Often	( ) Never
Drink Water:	___<64 oz/day	___>64 oz/day	( ) Never
Cigarettes:	___<1 pack/day	___>1 pack/day	( ) Never
Sleep:	___<8 hours/night	___>8 hours/night	( ) Insomnia

Other:_____

Family History: (Check all that apply)

( ) Arthritis: Parent / Sibling ( ) Heart Disease: Parent / Sibling
( ) Cancer: Parent / Sibling ( ) Hypertension: Parent / Sibling
( ) Diabetes: Parent / Sibling ( ) Polio: Parent / Sibling
( ) Asthma: Parent / Sibling ( ) Depression: Parent / Sibling
( ) Stroke: Parent / Sibling ( ) Kidney Disease: Parent / Sibling
( ) Thyroid: Parent / Sibling

Other: _____

Occupational Activities: (Check one that best describes your job description)

( ) Administration ( ) Business Owner ( ) Clerical/Secretary ( ) Computer User
( ) Heavy Equipment operator ( ) Daycare/Childcare ( ) Construction ( ) Health Care
( ) Food Service Industry ( ) Medium Manual Labor ( ) Manufacturing ( ) Home Services
( ) Heavy Manual Labor ( ) Light Manual Labor ( ) Executive/Legal ( ) Housekeeper

HISTORY OF COMPLAINT(S)

Please list in order of importance all complaints and symptoms you are currently experiencing that brought you to this office.

PRIMARY (CHIEF COMPLAINT) _____
When and how did it occur:_____

AFFECT OF CONDITIONS ON ACTIVITIES OF DAILY LIVING

Patient Name _____ File # _____ Date _____
Initial Exam _____ Re-activation _____ Re-evaluation Exam _____
Vitals: Height _____Weight _____ Blood Pressure _____ Pulse _____

Description of Work: _____

Condition's Effect On Job Performance:

□ **No Effect** □ **Mild** (painful can do) □ **Mod** (painful limited ability
□ **Mod/Severe (**limited duty) □ **Severe** (no limited duty) □ **Severe** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance:

Bending: □ **No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Care –Infirm Family: □ **No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Carrying Groceries: □ **No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Change To Sit-Stand: □ **No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Climb Stairs: □ **No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Driving: □ **No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Extended Computer Use:□**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Feeding: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Household Chores: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Kneeling: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Lift Children: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Lifting: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Pet Care: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Reading (Concentration):□**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Self Care–Bathing: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Self Care–Dressing: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Self Care–Shaving: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform Sexual Activities: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform
Sleep: □**No Effect** □**Mild** Painful (Can do) □**Mod** Painful (Limited) □**Severe** Unable to Perform

REVIEW OF SYSTEMS

Have you had or are you currently experiencing any of the following symptoms?
(Check all that apply)

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis / Allergies
__ Sore Throats
__ Tonsillitis

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

ARE YOU PREGNANT
( ) Yes ( ) No

MEDICATION / VITAMIN LIST

Please list all prescription, non-prescription medications and vitamins currently taking:

_____

_____

_____

INFORMED CONSENT FOR CHIROPRACTIC AND ACUPUNCTURE TREATMENT

Patient: Please discuss any questions or concern with the Doctor before signing this consent.

You have a right as a patient to be informed about your condition and the recommended use of chiropractic adjustments (and other chiropractic procedures) or acupuncture to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I _____ hereby request and consent to the performance of acupuncture (including needling, cold laser pen and micro current pen), chiropractic adjustments and other chiropractic procedures, including various models of physical therapy, on me (or the patient named below for whom I am legally responsible), by Dr. James Martell. I have had the opportunity to discuss with Dr. Martell my diagnosis, the nature and the purpose of chiropractic adjustments, acupuncture, and other procedures and alternatives.

Spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to soreness, dizziness, fractures, disc injuries, strokes(01/1 million), dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I understand and I am informed that acupuncture minor bruising, organ puncture, infection, local tenderness, drowsiness.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____ _____
Patient Signature (parent if minor) Date

_____ _____
Doctor Signature Date

Appointment / Communication Preferences:

☐ I would like to receive appointment reminders from this office via phone.
Preferred Phone Number: (_____) _____ - _____

☐ I would like to receive appointment reminders from this office via text message
Preferred Phone Number: (_____) _____ - _____

☐ I would prefer not to receive any appointment reminders from this office.

HIPAA Notice:
I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

_____ _____
Patient Signature (parent if minor) Date