Dr. Rebecca Scandura, D.C. ~ Whole Focus Chiropractic ~ Confidential Patient Record

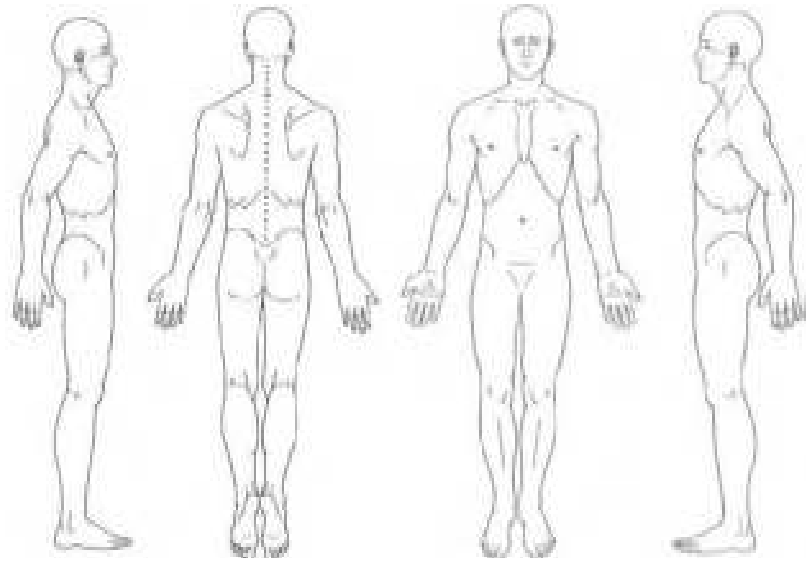
Patient Information

Patient Name _____ *Date* _____
Address _____ *Phone* _____
Email _____ *Birthday* ___/___/_____ *Age* _____
Emergency Contact _____ *Phone* _____
Family doctor _____ *Location* _____
Whom should we thank for referring you to this office? _____

Chief Complaint Information

Describe your symptoms _____
When did your symptoms start? _____
How did your symptoms begin? _____
Did this begin ○ *Immediately* ○ *Gradually* ○ *From an injury*
Have you had similar symptoms in the past? ○ *Yes* ○*No*

Mark the body diagram to show where you currently feel pain or other symptoms



How does it feel? (mark all that apply)
○*Dull ache* ○ *Sharp* ○ *Shooting*
○ *Burning* ○ *Tingling* ○ *Numb*
○ *Other* _____

How often do you experience this?
○ *Constantly (100%)* ○ *Frequently (75%)*
○ *Often (50%)* ○ *Seldom (25%)*
○ *Rarely (0-24%)*

How are your symptoms changing?
○ *Worsening* ○ *Improving* ○*Unchanged*

Rate your pain
0 =no pain and 10 =worst pain imaginable

At WORST	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
At BEST	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
RIGHT NOW	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

What have you tried that makes your symptoms better? _____

What have you tried that makes your symptoms worse? _____

Who have you seen for your symptoms? ○ *No one* ○ *Chiropractor* ○ *Physical Therapist*
○ *Medical Doctor* ○*Other* _____

-What treatment did you receive and when? _____
-What tests have you had for your symptoms and when were they performed? ○ *X Rays date:*_____ ○ *CT Scan date:*_____ ○ *MRI date:*_____ ○*Other date:*_____

What are your goals for seeking care here? _____

Activities of Daily Living: *Indicate how your current condition affects your ability to perform the following activities.*

*Mark an **"M"** to indicate **Mild Limitation** (you can perform the activity, but doing so causes pain)*
*Mark an" **MO"** to indicate **Moderate Limitation** (activity is limited)*
*Mark an **"S"** to indicate **Severe Limitation** (unable to perform)*

___Bending	___Carrying groceries	___Change from sit to stand position
___Climbing stairs	___Driving	___Extended Computer Use
___Exercise/Sports	___Household Chores	___Kneeling
___Lifting	___Pet Care	___Reading/Concentration
___School Work	___Self Care: Bathing	___Self Care: Dressing
___Sexual Activity	___Sleep	___Sitting
___Standing	___Walking	___Work Activities
___Yard Work	___Other _____	

Family History: ○ *Single* ○ *Married* ○ *Divorced* ○ *Widowed*
Names and Ages of Children: _____

Mark the following if your mother, father, siblings or grandparents had any of the following:

○ *Arthritis* ○ *Asthma* ○ *Autoimmune Disorder* ○ *Cancer* ○ *Diabetes*
○ *Heart Disease* ○ *Mental disorder* ○ *Stroke* ○ *Thyroid Problem*

Occupational History

*Occupation*_____ *Employer* _____

Work status	○ *Full-time*	○ *Part-time*	○ *Full time parent/spouse*	
	○ *Unemployed*	○ *Retired*	○ *Disabled*	○ *Student*
Work activities	○ *Sitting*	○ *Computer*	○ *Driving*	○ *Standing*
	○ *Bending*	○ *Light Labor*	○ *Heavy Labor*	○ *Other* _____
Work exposures	○ *Loud Noise*	○ *Vibration*	○ *Poor Ventilation*	○ *Excessive Heat/Cold*
	○ *Radiation*	○ *Poor Lighting*	○ *Toxic Chemicals, Dusts, Fumes*	
	○ *Other*_____			

Do you enjoy your work? ○ *Yes* ○ *Mostly* ○ *Somewhat* ○ *No*

Medical History

List current health problems for which you are currently being treated _____
_____

Current Medications and reason _____
_____

Give date(s) of occurrence and briefly describe. Include any significant complications (if any).

Motor Vehicle Accidents/Accidents _____
Major Injuries _____
Major Illnesses _____
Hospitalizations _____
Surgeries _____

***Review of Systems**: **Circle** if you have it **now**, or **underline** if you had it in the **past**.*

General :	*Fever/Chills*	*Unusual fatigue*	*Weight gain/loss >10 lbs.*	
Eyes :	*Pain/Pressure*	*Flashing Lights*	*Blind Spots*	*Double Vision*
Ear,Nose,Sinus:	*Hearing Loss*	*Noises in Ears*	*Pain/Fullness in Ears*	*Sinus problems*
Mouth, Throat:	*Dentures*	*Mouth/Tooth Pain*	*Swallowing Difficulty*	*Hoarseness*
***Head, Neck**:*	*Facial Pain*	*Facial Paralysis*	*Neck Masses, Lumps*	
Cardiovascular:	*Chest Pain*	*Heart Disease*	*Heart Condition*	*Palpitations*
	Ankle swelling	*High blood pressure*	*Leg cramps/calf pain*	*Varicose Veins*
***Respiratory**:*	*Coughing blood*	*Shortness of Breath*	*Breathing Difficulty*	
GI:	*Poor/Excessive Appetite*	*Excessive Gas/Bloating*	*Ulcers*	*Heartburn*
	Vomiting/Nausea	*Abdominal Pain*	*Diarrhea*	*Constipation*
	Blood in stool	*Gallbladder disease*	*Liver disease*	
Genitourinary:	*Difficulty/pain urinating*	*Incontinence*	*Kidney Stones*	*Venereal Disease*
Men Only:	*Lump in Testicle*	*Painful Testicle*		
Women Only:	*Menstrual Problems*	*Miscarriage*	*Menopause*	*Date last period _____*
	Are /may you be pregnant? N Y Due Date_____		*# pregnancies_____*	*# live births_____*
Integumentary:	*Lump in Breast*	*Painful Breasts*	*Unusual Hair Loss*	*Bruise easily*
	Rash/Itching	*Changes in Moles/Nails*	*Fungal Infection*	*Enlarged lymph node*
***Musculoskeletal**:*	*Joint pain/Arthritis*	*Stiffness*	*Swollen Joints*	*Muscle ache*
	Bone pain	*Jaw Pain, Clicking*	*Back Pain: Upper, Mid, Lower*	
	Pain or Numbness in: Shoulder, Elbow, Wrist, Hands, Fingers, Hip, Knee, Ankle, Foot, Toes			
Psychologic:	*Excessive Anxiety*	*Excessive Stress*	*Sleep Difficulties*	*Depression*
	Mental Disorder	*Alcoholism*	*Drug Addiction*	*Psychiatric Care*
Neurologic:	*Headaches*	*Migraine*	*Dizzy/Lightheaded*	*Lost Consciousness*
	Seizures/Epilepsy	*Numbness/Tingling*	*Weakness*	*Stroke*
Endocrine:	*Thyroid Problem*	*Unusual cold/hot*	*Hot flashes*	*Increased Thirst*
Hematologic:	*Varicose Veins*	*Anemia*	*Stroke*	*Allergies*
	Autoimmune Disease			

Social History

In general, how would you say your overall health is right now?	○ *Excellent* ○ *Very good* ○ *Good* ○ *Fair* ○ *Poor*
Current level of stress	*low 0 1 2 3 4 5 6 7 8 9 10 high*
Major causes of stress	_____
Tobacco Usage (include past use)	*Cigarettes: #/d _____ Cigars: #/d _____ Chewing: oz/d _____*
Alcohol Intake	*Wine: oz/d or wk_____ Liquor: oz/d or wk _____ Beer: oz/d or wk _____*
Caffeine Intake	*Coffee: oz/d or wk_____Soda: oz/d or wk _____ Tea: oz/d or wk _____*
Water Intake	*oz/d _____*
Exercise	*Days/wk_____ Min/Session _____What types?_____*
	Intensity: ○*Mild* ○*Moderate* ○*Heavy* ○*Elite*
Nutrition and Diet	○*Balanced* ○*Unhealthy* ○*Excessive* ○*Restrictive* ○*Special Diet*
Current Supplements	_____
Describe your sleep	○*Restful* ○*Difficulty falling asleep* ○*Wake up often*
	○*Wake up groggy* ○*Pain wakes you up at night* ○*Nightmares*
Allergies (food, environmental, drug)	_____
Is there anything else you feel Dr. Scandura should know about you?	_____
	_____

*Signature*_____ *Date* _____

Dr. Rebecca Scandura, D.C. ~ Whole Focus Chiropractic

Informed Consent to Spinal Manipulation, Supportive Care and Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including physical examination, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or her preceptor and/or other licensed doctors of chiropractic who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for the doctor of the chiropractic named below.

I have had an opportunity to discuss with the doctor named below, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click."

There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I realize that the practice of chiropractic, like the practice of medicine, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I understand that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including, but not limited to, soreness, dizziness, fractures, joint injuries, disc injuries, strokes, dislocations and sprains. I understand that in isolated cases with the presence of underlying physical defects, deformities or pathologies, the patient may be susceptible to injury. I will inform the Doctor if I have such underlying conditions if and when I become aware of it, if I have not done so already. I understand that when osteoporosis, a degenerative disc, or other abnormality is detected, the office will proceed with extra caution. I understand that although strokes happen with some frequency in our world, strokes caused by chiropractic adjustments are rare. I am aware that nerve or brain damage, including stroke, is reported to occur 1 in 1,000,000 to 1 in 10,000,000 treatments.

It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand and comprehend all such risks and complications. I have read or have had read to me the above explanation of chiropractic treatment. The doctor, if necessary, has provided further explanation and I am satisfied with my understanding of this informed consent. I have weighed the risks and made my decision voluntarily and of my own free will and I agree to undergo care at Whole Focus Chiropractic with Dr. Rebecca Scandura.

_____ ___/___/_____

Signature Date

Acknowledgement of Privacy Notice

I acknowledge that the Privacy Notice for Whole Focus Chiropractic has been made available to me and that I have read the Privacy Notice and understand my rights as described in it. By way of my signature, I provide Whole Focus Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ ___/___/_____

Signature Date

No-Show and Cancellation Policy

By way of my signature, I acknowledge that Whole Focus Chiropractic requires a minimum 24 hour cancellation notice on all appointments and that no-shows or cancellations with less than 24 hours notice will be billed $25.

_____ ___/___/_____Signature

Date