

Welcome to Buda Family Chiropractic

Please fill out the following form in as much detail as possible. Please know that all information will be kept confidential.

Patient Information

Patient name _____
Today's date _____ Date of birth _____
Social Security # _____
Address _____
City _____
State _____ Zip _____
Gender: Male Female Height _____ Weight _____
 Single Married Partnered Engaged
 Separated Divorced Widowed Minor
How many children do you have? _____
Please list any family members being treated here _____

Occupation _____
Employer/School _____
Employer/School address _____

Employer/School phone number (_____) _____
Spouse's/Partner's name _____
Spouse's/Partner's employer _____
Who referred you? _____

Contact Information

Home phone (_____) _____
Cell phone (_____) _____
We pride ourselves in educating our patients on their condition with 20 short daily emails. So that you receive this important information, provide us with your email address here:
Email address _____
In case of emergency please contact:
Name _____
Relationship _____
Home phone (_____) _____
Work/Other phone (_____) _____

Mission Statement

Our Passion is to share and celebrate in the healing journey of every family and individual who chooses to be lovingly served by us in a relaxed atmosphere.

We recognize health is an inherent state of well-being in mind, body and spirit. Our role is to remove any interference to health expression through optimal chiropractic and nutritional care supported by wellness education.

Our goal is to help create a world of maximized health and optimum human potential.

How Safe Is Chiropractic? How Do You Define Safe?

Years of training and the experience of giving thousands of adjustments make chiropractic care safe.

Even with clear warnings in the media and sun screening products, 6,000 people will die this year from skin cancer. Chiropractic care is much safer than getting a so-called "healthy" tan.

Many people take aspirin, ibuprofen, muscle relaxers, and other pain relief drugs. Besides covering up the symptoms and ignoring the underlying causes, 4,000 people will die this year from reactions to medically-prescribed drugs. Chiropractic care is much safer than drug therapy. Most people consider aspirin safe, yet a staggering number of people will die this year from its use. Chiropractic care is much safer.

While commercial airplane mishaps get a lot of publicity, estimates suggest that fewer than 300 people will die this year from flying on commercial aircraft. Chiropractic care is much safer than flying.

Every year, about 100 people get struck by lightning. You are more likely to get hit by lightning than to have a negative reaction to a chiropractic adjustment. Chiropractic is safer than being caught in a thunderstorm.

In fact, of the millions of patients who will benefit from chiropractic care this year, only a handful will have a newsworthy experience.

Is chiropractic care safe? Yes! Especially when compared with other forms of treatment.

Patient Condition

What is your major complaint (*be as specific as possible*) _____

When did your condition/symptoms/pain first appear? (*specific date, days ago, weeks ago, etc*) _____
Is this condition getting progressively worse? Yes No Constant Comes and goes
Since the onset of your problem is it: Getting worse Staying the same Slow to improve
When is it worse? Morning Afternoon Evening
Does it interfere with: Work Sleep Daily routines Other _____
How long has it been since you really felt good? _____
Other doctors seen for this condition: MD DC DO DDS Other _____

Patient Condition

Does the condition/symptom/pain radiate? Yes No

If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Do you have: Numbness Tingling Weakness

Describe _____

List and mark the severity of your condition/symptoms/pain on the scales below:

Body part _____
0 (None) 5 (Severe) 10

Body part _____
0 (None) 5 (Severe) 10

Type of Pain: sharp dull aching throbbing numbness
 shooting burning tingling Other _____

What activities or positions aggravate your condition?

bending coughing getting up/down driving lifting lying down reaching sitting
 sneezing standing straining at stool turning head twisting walking Other _____

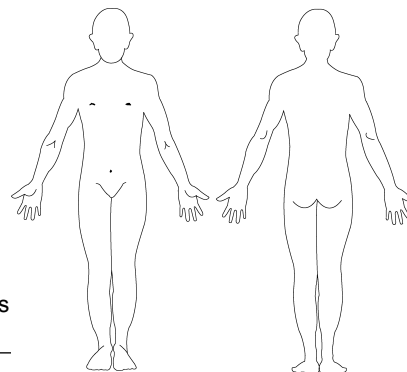
What activities or positions relieve your condition?

heat ice lying down medication sitting standing stretching Other _____

Have you ever had this condition before? Yes No If yes, when? _____

Were you treated for this condition or a similar one before? Yes No If yes, when/by whom? _____

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Health History

Do you have any allergies? (food, contact, environment) _____

List any prescribed medications, over the counter medications, vitamins, herbs, and supplements _____

When was your last: Physical examination? _____ Blood/lab work? _____ X-ray study? _____

Injuries/Surgeries you've had and when? _____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below.***

Ankylosing spondylitis <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel/Bladder problems <input type="checkbox"/> Yes <input type="checkbox"/> No Buzzing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Carpal tunnel <input type="checkbox"/> Yes <input type="checkbox"/> No Celiac disease (gluten) <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pains <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Cold hands or feet <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis/Diverticulitis <input type="checkbox"/> Yes <input type="checkbox"/> No Compression fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Connective tissue issues <input type="checkbox"/> Yes <input type="checkbox"/> No COPD (bronchitis/emphy) <input type="checkbox"/> Yes <input type="checkbox"/> No	Cushing's disease <input type="checkbox"/> Yes <input type="checkbox"/> No Cystic medial necrosis <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Digestive/Bowel problems <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness or vertigo <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromuscular dysplasia <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No Fusions (spinal, joint, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No Gout <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis (A, B, C, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Hip replacement <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Knee surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No Marfan syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis/penia <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's disease <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Rotator cuff problem <input type="checkbox"/> Yes <input type="checkbox"/> No STI/STD <input type="checkbox"/> Yes <input type="checkbox"/> No Shoulder surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke/TIA <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ Other _____ Other _____
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Are there any conditions that run in your family? Yes No If yes, what condition(s) and which family members? _____

For Women Only

Do you currently or have you ever used birth control? Yes No If yes, what brand(s), dosage, when, and for how long?

Do you currently or have you ever taken hormone replacement medication? Yes No If yes, what brand(s), dosage, when, and for how long? _____

Are you currently pregnant, or do you think you may be pregnant? Yes No If yes, for how many weeks? _____

Personal and Social Health History

How many hours per week do you typically work/attend school? <20 hrs 20 hrs 30 hrs 40 hrs 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc)? _____

Do you exercise? Yes No If yes, how often and what type? _____

Do you or does anyone else ever "crack" your neck/back/joints? Yes No If yes, how often and what body part(s)? _____

How would you rate your eating habits? Excellent Pretty good Could be better Needs improvement

Do you follow a specific nutritional program? Yes No If yes, what type? _____

Would you like help with your diet or have a nutritional program developed for you? Yes No

Habits? Tobacco: Packs/Day _____ Alcohol: Drinks/Week _____ Caffeine: Cups/Ounces/Day _____

Other habits? _____

How well do you sleep? Excellent Pretty good Restless Can't Sleep

How many hours of sleep do you get daily? _____ *and* Do you feel well rested in the morning? Yes No

How is your energy overall? Full power Ok Low Sporadic/Generally fatigued

How do you feel your immune system is? Strong Ok Low

In your own words, what do you think chiropractors do? _____

What do you hope to receive from our program? _____

Other than the current condition(s) for which you are here today, are there any other conditions that you have that you would like to have checked by the doctor? Yes No If yes, describe? _____

Please add any comments here _____

Permission to Test and Treat

I hereby request and consent to the administration of diagnostic procedures, chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical therapy and diagnostic x-rays administered by the staff at Buda Family Chiropractic. I have been informed of the benefits and risks of chiropractic care and understand it is my responsibility to ask questions. I attest that the information completed by me on this form is correct and true to the best of my knowledge and agree to notify this office in the event of any change. Payment is expected for all office visits, services, treatments, procedures, and products purchased at the time of each visit unless other arrangements have been made with the business office personnel.

Signature of Patient or Guardian

Printed Name of Patient or Guardian

Date

Thank you for completing our health care questionnaire