

Patient Health History

Dr. Stephen Tranter, DC, FIAMA

Name _____ Nickname _____ M F M S W D

Address _____ Date / Birth _____ # Children _____

Best Contact Phone # _____ Circle: Landline? Cell? OK to Receive Texts? _____

Occupation _____ Employer _____ Work # _____

Email _____ Spouse / Parent _____

Whom May We Thank For Referring You? _____

Purpose Of Today's Visit / Complaints _____

Please check:

- | | | |
|--|--|--|
| <input type="checkbox"/> Hepatitis MRSA HIV AIDS | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Cancer history | <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Slow healer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Weak immune system | <input type="checkbox"/> Joint or muscle pains |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Food Sensitivities | <input type="checkbox"/> Nerve pains |
| <input type="checkbox"/> Anti-coagulant medication | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic stress |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sensitive to medication | <input type="checkbox"/> Women: I am, may be, or planning to become pregnant |
| <input type="checkbox"/> Male or female problems | <input type="checkbox"/> Chronic fatigue | |

Benefits, risks and consent for care

Physical medicine is generally regarded as safe when applied by a skilled practitioner. All medical procedures pose some element of risk, so please carefully read the following:

Your evaluation may include active and passive joint movement, palpation and muscle testing. If you are currently in pain, this evaluation may temporary increase your pain.

Your treatment may include low and no-force joint and muscle treatment, acupressure, acupuncture and/or related therapy. Occasionally, patients experience soreness, discomfort, aching, mild bruising or a temporary increase in pain. As with any physical medicine, there is a rare possibility of injury to muscles, joints, ligaments, tendons, blood vessels, nerves or internal organs.

To gain maximum improvement from your care, multiple treatments over a specific amount of time are typically required, and your participation and follow-through is vital.

* I have carefully read and understand the benefits and risks involved, and voluntarily consent to evaluation and care. If I have any questions / concerns about any procedure, I will immediately inform a staff member.

Patient Signature, or Guardian authorizing care

Date

Name _____

For what problem(s) are you seeking care? _____

When did you first notice this problem? _____

Has it worsened recently? _____ If yes, when and how? _____

How frequent is your problem? _____

How long does it last? _____

Have you ever had the same or similar problem? _____ If yes, when? _____

What other symptoms or conditions may be related to this problem? _____

If pain is involved, is it: sharp dull throbbing stabbing aching burning tingling shooting?

What do you do to try to provide relief? _____

What makes the problem worse? _____

List accidents, surgeries or broken bones _____

Family Doctor _____ Town _____

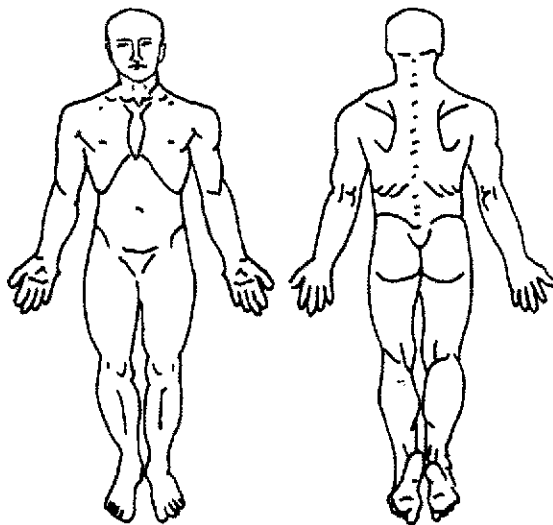
Family Chiropractor _____ Town _____

May we update your doctor with results of your examination and or treatment? _____

Please rate the severity of your condition:

Forgotten with activity _____ Interferes with activity _____ Stops activity _____

Please indicate your area of complaints:



Patient or Guardian Signature

Date

Welcome! We are excited to serve your health care needs in an effective and efficient manner. Please select times that would work best for your follow-up visits.

Please circle **all** that might apply.

MONDAY: Early Afternoon Late Afternoon

TUESDAY: Early Afternoon Late Afternoon

WEDNESDAY: Early Afternoon Late Afternoon

THURSDAY: Early Afternoon Late Afternoon

Clinical Hours are: Mon. – Thurs. 12:15pm – 5:30pm