AUERBACH CHIROPRACTIC
ARTS AND SCIENCE

Dr. Gary Auerbach
2730 N. Pantano Road Tucson, AZ 85715
Phone: 520-721-7177

Welcome to the office of Auerbach Chiropractic Arts and Science. In order to better serve your needs, please fill out the following forms prior to your first appointment so we can better assess your current health status. Thank you for your cooperation in these responses. Below is a brief background and explanation of care that may be provided.

- A Doctor of Chiropractic is a primary care, portal of entry health care provider who engages in a practice of health care that uses the inherent recuperative healing qualities of the human body. It is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

- A subluxation, or vertebral subluxation complex (VSC), is a misalignment of one or more of the 24 movable vertebra of the spine including the head and pelvis. There are five components of a misalignment of a vertebra (subluxation) including bone, nerve, ligaments, muscles and soft tissues. A subluxation causes an alteration to nerve function and interference to the transmission of the mental impulse, resulting in a reduction of the body's ability to heal itself.

- An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation complex. Our chiropractic method of correction is by specific adjustments of the spine by hand, with an adjusting instrument, or using the Sacral Occipital Technique (SOT). In the course of our treatment, we may recommend exercise or other methods for stress reduction.

- There is a need to establish a proper diagnosis to identify and correct any existing vertebral subluxations. This creates a more normal internal environment of the body for the restoration and maintenance of health. Diagnosis means the determination and nature of a condition or illness.

- A patient record allows for sufficient information to identify the patient, support the diagnosis, identify the specific elements of the chiropractic service performed, indicate special circumstances or instruction, and identify a treatment plan.

If in the course of our consultation and physical exam to evaluate your overall health we encounter non-chiropractic or unusual findings, we may advise you to seek advice, diagnosis, or treatment from other health care providers.

I have read and understand the above statements and I accept chiropractic care on this basis.

_____
(Type Name)

_____ _____
(Signature) (Date)

Name: _____ Date: _____

HEALTH INSURANCE INFORMATION:

Do you have health insurance? ◯ NO ◯ YES If YES, please fill in details below.

Insured Name: _____

Insurance Company: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Phone: _____

Group/Policy: _____

Member ID: _____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
(Parent Name) (Childs Name)

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____
(Signature) (Date)

PATIENT HISTORY

If this injury or illness is either ◯ **WORK RELATED** or due to an ◯ **AUTO ACCIDENT**,
Please inform the receptionist at check-in.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Gender: ◯ Male ◯ Female

Date of Birth: _____ Age: _____ Height: _____ in Weight: _____ lbs

Your Occupation: _____

Your Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____

Spouse's Occupation: _____

Emergency Contact Name: _____ Phone Number: _____

How were you referred to this office?

○ Friend ○ Co-worker ○ Flyer ○ Advertisement ○ Phone Book ○ Event ○ Other

If by a friend, may we have the friend's name, so we can thank them for the referral?

_____

Thank you for your time in completing this part of our questionnaire and welcome to the Auerbach Chiropractic Arts and Science, Our goal is a healthier YOU, which takes us one step closer to a healthier World. Make sure you thank the person who referred you to us, and we hope you will refer others to us as well.

Name: _____ Date: _____

Welcome to Auerbach Chiropractic Arts and Science. Please help us to assist you better by completely filling out the next three forms. It is so we can have a better picture of your overall health.

YOUR HEALTH PROFILE:

Why these Forms are important: As a full spectrum chiropractic office, we focus on your ability to be healthy. Our first goal is to assess the REASON why you are here. Second, is to find out your health history, as it applies to you. Underlying conditions often times are responsible for your health today. Third, to put together a program custom fit to your needs.

The Beginning Years (to age 17): Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability by circling the correct answer. Please describe details on the **"comments"** line below.

Your Childhood Years Legend: y = Yes n = No u = Unsure

Were you vaccinated?	y	n	u	Did you take/use drugs?	y	n	u
Did you have any surgery?	y	n	u	Did you play youth sports?	y	n	u
Did you have any childhood illness?	y	n	u	Did you have any serious falls as a child?	y	n	u

Did you have chiropractic care as a child?	y	n	u
Did you suffer any traumas, physical or mental?	y	n	u
Were you involved in any car accidents as a child?	y	n	u
Have you had any falls out of a bunk bed, trees, crib, etc?	y	n	u
Was there any prolonged use of medications, i.e. antibiotics, or inhalers?	y	n	u

Adults (18 and older)

Did or do you smoke?	y	n	u	Did or do you play adult sports?	y	n	u
Did or do you drink alcohol?	y	n	u	Have you been in accidents?	y	n	u
Have you had surgery?	y	n	u	Did or do you participate in extreme sports?	y	n	u

On a scale of **1 to 10** describe your stress level: Occupational 0 Personal 0 (1=none 10=extreme)

On a scale of **Poor, Good, Excellent** describe your…

Diet: Select Exercise: Select Sleep: Select General Health: Select

Additional Comments:

Name: _____ Date: _____

MY REASON FOR SEEKING CHIROPRACTIC CARE TODAY IS…

If you are experiencing pain, is it...

○ Sharp ○ Dull ○ Comes and goes ○ Travels ○ Constant

Since the problem started it is...

○ About the same ○ Getting Better ○ Getting Worse

What makes it worse? _____

It interferes with? ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem?

Chiropractor's Name: _____

Medical Doctor's Name: _____

Other: _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & Needles in arms	☐ Dizziness	☐ Numbness in fingers
☐ Fatigue	☐ Sleeping problems	☐ Diarrhea	☐ Cold Sweats
☐ Mood Swings	☐ Pins & Needles in legs	☐ Loss of smell	☐ Buzzing in ears
☐ Numbness in toes	☐ Depression	☐ Neck stiff	☐ Constipation
☐ Lights bother eyes	☐ Menstrual pain	☐ Fainting	☐ Back pain
☐ Ringing in the ears	☐ Loss of taste	☐ Irritability	☐ Cold hands
☐ Fever	☐ Problems urinating	☐ Neck pain	☐ Menstrual irregularity
☐ Loss of balance	☐ Nervousness	☐ Stomach upset	☐ Tension
☐ Cold Feet	☐ Hot flashes	☐ Heartburn	☐ Ulcers

List any family member with same or similar conditions: _____

List any medications and doses you are taking: _____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluations.

Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING:

How does this condition currently interfere with your daily life and the ability to function?

On a scale of 0 - 10, 0 being No Effect and 10 being Severe Effect please complete the following.

Going to sleep	0	Walking	0	Reaching over head	0
Staying asleep	0	Standing	0	Looking over shoulder	0
Rising out of chair	0	Bending over	0	Household chores	0
Showering or bathing	0	Dressing myself	0	Using a computer	0
Driving a car	0	Sitting	0	Concentration / Balance	0

Reset?

Combined Total: **0**

What is the major stress factor in your life? _____

How many hours do you sleep per night? 0 hrs

What type of mattress do you have? _____

What type of pillow do you have? _____

Approximate age of current mattress? 0 years

Approximate age of current pillow? 0 years

What is your preferred sleeping position? Select

Which eating habit best describes you?

○ Skip Breakfast ○ Two meals per day ○ Three meals per day ○ Snacking between meals

What would be the most significant thing you could do to improve your health?

Besides the main reason for your visit today, what additional health goals do you have?

Name: _____ Date: _____

RANSFORD PAIN DIAGRAM

Note: This section must be completed manually with a pen or pencil once you have completed the form and you have successfully printed the entire packet.

On the drawing below, please indicate where you are experiencing pain by drawing in the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness = N	**Tingling = T**	**Dull Pain = D**
Sharp Pain = P	**Burning = B**	**Stiffness = S**