Bridgett N. Urban D.C. 3958 Harbor Light Landing, Port Clinton, OH 43452 **P: (419) 734-5353**

Patient Information Sheet

First Name____________________________ **M.I.** ____ **Last Name**____________________________

Address ____

City ________________________________ **State** ___________________ **Zip Code** ______________

Leave Messages on: (Circle one) ☐ Home ☐ Cell ☐ Work

Home Phone (_____) ________-___________ **Work Phone (_____) _________-____________**

Cell Phone (_____) ________-___________ **Email** ____________________________________

Date of Birth ______/______/_______ **Sex:** ☐ Male ☐ Female

Social Security Number: ______-_____-______ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data

Employer ____

Your Occupation ____

Spouse Data

First Name _________________________ **Middle Initial** ____ **Last Name** ______________________

Home Phone (_____) _______-__________ **Work Phone (_____) _______-_____________**

Spouse Date of Birth _____/_____/_______

Emergency Contact

Contact Name _____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone (_____) ________-______________**

Medical Conditions: (Circle all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _______________	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐Breast Augmentation	Other _______________		

Allergies: (Circle all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical ____________	Sulfites	☐ Wheat/Glutens	☐ Other __________

Social History: (Circle all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never	
Drink Alcohol:	☐ occasional	☐ often	☐ never	
Exercise:	☐ 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: (Circle all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling

Other __________________

Occupational Activities: (Circle 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
☐ Other _________________			

Please list all current medications being taken:

____

____

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Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular				**Respiratory**				**Allergic/Immunologic**			
	Past	Present	No		Past	Present	No		Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			
Jaw Pain				**Eyes**					Past	Present	No
Irregular Heartbeat					Past	Present	No	Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary				Blurred Vision				Sore Throat			
	Past	Present	No					Nosebleeds			
Kidney Disease				**Psychiatric**				Bleeding Gums			
Burning Urination					Past	Present	No	Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			
Kidney Stones				Stress					Past	Present	No
Lower Side Pain								Gall Bladder Problems			
				Endocrine				Bowel Problems			
Neurologic					Past	Present	No	Constipation			
	Past	Present	No	Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**							
Pinched Nerves					Past	Present	No	**Musculoskeletal**			
Parkinson's				Hepatitis					Past	Present	No
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional				Bleeding				Muscle Weakness			
	Past	Present	No	Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

* I certify the information provided on pages 1-3 of this "*Patient Information Sheet*" are accurate to the best of my knowledge.

____

Printed Name of Patient

x____

Signature of Patient Date

x____

Signature of Representative (if patient is minor or handicapped) Date

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

____

Printed Name of Patient

x____

Signature of Patient Date

x____

Signature of Representative (if patient is minor or handicapped) Date

x____

Witness to Patients' Signature Date