



WELCOME TO
PURE LIFE CHIROPRACTIC NEUROLOGY

Confidential Patient Information

Name		Date
Address		City/ State/ Zip Code
Home Phone	Work Phone	Cell Phone
Email Address	Date of Birth	Current Age
SSN:		

Work Status: Employed Retired Disabled Full-time Parent/Spouse Student

Employer	Occupation	
Employer Address	City State	Zip Code

Marital Status: please circle Married Single Divorced Widow

Spouse's Name/Cell Phone _____

Previous Chiropractic Care? Yes No Doctor's Name: _____

Name of Your Insurance Company _____

Who (or what source) referred you? _____

Please list your major complaints in order of severity (form most debilitating to least debilitating):

Please circle the single greatest complaint below

1 _____ 2 _____ 3 _____

When did you first notice this condition? _____

Did it begin: Immediately or Gradually?

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms?

- Constant (100% of day)
- Frequent (75%)
- Often (50%)
- Seldom (25%)
- Rarely (less than 25%)

Is this condition progressively: Worsening Improving Unchanged

What is the intensity of you symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)

1 2 3 4 5 6 7 8 9 10

Please indicate the character of your pain: __ Dull __Sharp __Burning __Aching __Knife-like __Throbbing

Other: _____

Are you experiencing any of the following associated symptoms?

- __Pins/Needles
- __Tingling
- __Numbness
- __Twitching

If yes, please describe:

WORSE: Please indicate what activities aggravate your condition:

BETTER: Please indicate what helps alleviate the pain.

Please list any doctors and/or treatments you used for this condition. (Please include diagnoses, treatment received, supplements/medications and any changes in your condition):

Please include any other relevant history you feel Dr. Borbón should know.



Neurovascular Review

Please Circle the Appropriate Response

1. Are you over the age of 35? Yes No
2. Have you ever suffered from headaches? Yes No
3. Do you have family history of cardiovascular disease or stroke? Yes No
4. Do you have high blood pressure? Yes No
5. Do you suffer from dizziness or light-headedness? Yes No
6. Do you smoke or have you smoked in the past? Yes No
7. Have you ever experienced tingling or numbness of arms or legs? Yes No
8. Do you bruise easily? Yes No
9. Do you get tired easily or fatigued after common physical activity? Yes No
10. Do you have a stressful lifestyle? Yes No
11. Do you exercise regularly? Yes No
12. Do you get at least 7 hours of sleep each night? Yes No
13. Do eat three balanced meals a day? Yes No
14. Do you take birth control pills? Yes No
15. Do you have varicose veins? Yes No
16. Do you suffer from Diabetes? Yes No
17. Do you have any swollen or stiff joints? Yes No

Past Medical History

Please include any of you previous conditions

If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls, or Traumas (Including Sport Injuries) <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

Motor Vehicle Accidents <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
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Females Only: Menopausal Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Yes Explain:
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Habits

Cigarettes/Cigars <input type="checkbox"/> None <input type="checkbox"/> Yes	How much per week?		
Alcohol <input type="checkbox"/> None <input type="checkbox"/> Yes	How many drinks per week?	What types of alcohol?	
Coffee <input type="checkbox"/> None <input type="checkbox"/> Yes	How many cups per week?		
Exercise <input type="checkbox"/> None <input type="checkbox"/> Yes	Hours/Days per week?	Types?	
Water <input type="checkbox"/> None <input type="checkbox"/> Yes	Glasses per day?		
Soft Drinks <input type="checkbox"/> None <input type="checkbox"/> Yes	Amount per week?	Types:	
Sleep <input type="checkbox"/> None <input type="checkbox"/> Yes	Average per night?	Do You have difficulty falling asleep or staying asleep ?	Hours desired per night?
Eating	Meals per day? _____	Do you consider your diet healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain	

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

Please specify the relation to persons below.

<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological Disorders <input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Autoimmune Disorders _____ <input type="checkbox"/> Cancer _____
<input type="checkbox"/> Other _____

**Authorization And Consent To Chiropractic
Adjustments, Special Procedures And/Or Therapy
And Consent to Payment/Cancellation/Reschedule Policy**

Printed Name: _____

Pure Life Chiropractic Neurology maintains personnel and facilities to assist your doctor in the performance of chiropractic adjustments, special diagnostic, and other therapeutic procedures. These adjustments and ancillary procedures all may involve a calculated risk of complication, injury, or even death, from both known and unknown causes and no warranty of guaranty has been made as to the result or cure. Except in emergency or exceptional circumstances, these therapies and procedures are therefore not performed on patients unless and until a patient has had an opportunity to discuss them with his/her doctor. Each patient has the right to consent or refuse any proposed procedure or therapy based upon the prescription or explanation received.

The doctor(s) has determined that until the procedure(s) listed below may be beneficial in the diagnosis or treatment of your condition. Upon your authorization of your consent, such therapies or special procedures will be performed by your doctor.

Your signature opposite the procedure(s) listed below constitutes your acknowledgement(s) that:

- (1) You have read and agreed to the foregoing;
- (2) The procedure(s) and possible alternate means of therapy have been adequately explained to you by your doctor;
- (3) You consent to the office policy and procedure(s) or specified tests;
- (4) You consent to procedures and tests in addition to or different from those specified below, whether or not arising from presently unforeseen conditions, which your doctor might consider necessary or advisable in the course of the procedure(s) specified below;
- (5) No guaranty of a cure has been promised to you.

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone or e-mail a minimum of 24 hours in advance. The payment/cancellation/reschedule details listed here define our Office Policy. The Office Policy supports the greatest ability to serve those desiring an appointment.

For consultations and exams of new patients with a friend/family or professional referral discount, failure to provide such notice will result in forfeiture of the savings offered.

For appointments, if you do not cancel by the deadline, you will be assessed a \$48.00 missed appointment fee. This fee is will be your responsibility to pay at the time of your next visit or will be deducted from any prepayment on file. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated.

Patient treatment plans are meticulously formulated on a patient by patient basis. Recommended frequencies and time frames of implementation of the treatment plan will be covered with the patient prior to its commencement. No action will take place without the full agreement of the patient. Therefore, failure of the patient to fulfill his/her duties of the treatment plan is the responsibility of the patient. This includes, but is not limited to, not showing up for the treatments. In such a case where thirty days has elapsed since the previous patient visit, during the correctional treatment phase, no refund will be made available. The patient's initiation of the treatment plan is the agreement that he/she will complete it.

I, (Printed Name) _____, understand and give my consent to the information above as well as to the physical exam, chiropractic adjustment, ancillary therapy(ies), and office policy.

Signature: _____ Date: _____

If Minor:

Guardian's Name: _____ Relation: _____ Date: _____