LIFETIME Spines
ADULT AND PEDIATRIC CHIROPRACTIC

Dr. Sorayya Toloue, DC

Name:____ Date: ___________________________
Address: ______________________________________ City/State/Zip: ____________________
Email Address: _________________________________ Marital Status: M S D W
Cell Phone: ____________________________________ Birth Date: __________ Age: _________
Occupation: ___________________________________ Employer: ________________________
Spouse's Name: _________________________________ Spouse's Employer: ________________
Children's Names and Ages: ____
Emergency Contact/Phone Number: ____
Who may we thank for referring you: ____

Current Health Concerns/Date these conditions started:
1.____
2.____

Other Doctors you have seen for this problem: ____
Is this condition a result of an accident: YES NO AUTO Workers Comp Other:_______
Insurance Carrier: _________________________________ Are you eligible for Medicare: YES NO

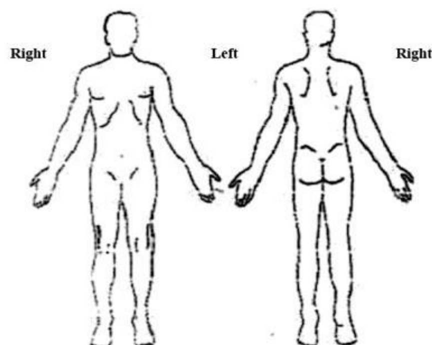
Describe your Pain (circle)

Headache	sharp	dull	ache	radiating	numbness
Neck Pain	sharp	dull	ache	radiating	numbness
Mid back Pain	sharp	dull	ache	radiating	numbness
Low Back Pain	sharp	dull	ache	radiating	numbness
Shoulder Pain (R or L)	sharp	dull	ache	radiating	numbness
Arm Wrist Hand Pain (R or L)	sharp	dull	ache	radiating	numbness
Hip Pain (R or L)	sharp	dull	ache	radiating	numbness
Leg Ankle Foot Pain (R or L)	sharp	dull	ache	radiating	numbness

Grade pain level (circle)

Headache	no pain	0	1	2	3	4	5	6	7	8	9	10	extreme pain
Neck Pain		0	1	2	3	4	5	6	7	8	9	10	
Mid back Pain		0	1	2	3	4	5	6	7	8	9	10	
Low Back Pain		0	1	2	3	4	5	6	7	8	9	10	
Shoulder Pain (R or L)		0	1	2	3	4	5	6	7	8	9	10	
Arm Wrist Hand Pain (R or L)		0	1	2	3	4	5	6	7	8	9	10	
Hip Pain (R or L)		0	1	2	3	4	5	6	7	8	9	10	
Leg Ankle Foot Pain (R or L)		0	1	2	3	4	5	6	7	8	9	10	

Please Mark your Areas of Pain:



MEDICAL HEALTH HISTORY: Please circle any/all that apply

Musculoskeletal

Osteoporosis	Scoliosis	Back Problems	Knee injuries
Poor Posture	Foot/Ankle pain	Neck Pain	Hip/Joint Disorders
Elbow/Wrist pain	Shoulder problems	TMJ	Arthritis

Other/Details:____

Neurological
Anxiety
Depression
Headaches/Migraines
Dizziness
Pins and Needles
Numbness
Other/Details:___________

Cardiovascular
High Blood Pressure
Low Blood Pressure
High Cholesterol
Poor circulation
Angina
Excessive bruising
Other/Details:___________

Respiratory
Asthma
Apnea
Emphysema
Hay fever
Shortness of Breath
Pneumonia
Other/Details:__________

Digestive
Anorexia/Bulimia
Ulcer
Food Sensitivities
Heartburn
Constipation
Diarrhea
Other/Details:___________

Sensory
Blurred vision
Ringing in ears
Hearing loss
Chronic ear infections
Loss of Smell/Taste
Other/Details:___________

Endocrine
Thyroid Disease
Immune disorders
Hypoglycemia
Frequent infection
Swollen Glands
Low energy
Other/Details: __________

Genitourinary
Kidney stones
Infertility
Bedwetting
Prostate issues
Erectile Dysfunction
PMS symptoms
Other/Details:___________

Integumentary
Skin Cancer
Psoriasis
Eczema
Acne
Hair Loss
Rash
Other/Details:___________

Constitutional
Fainting
Low libido
Poor appetite
Fatigue
Sudden weight change
Weakness
Other/Details:__________

Family Health History: (Mother, Father, Brothers/Sisters) ____________________________________
Past Surgeries: ____
Current Medications: ____
Are you currently pregnant? ____
Have you ever been diagnosed with cancer? If so when? ____________________________________

Informed Consent

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing are from medicine and does not proclaim to cure any named disease or entity.

I understand that I may request a copy of the HIPPA and Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

I grant permission to be called or texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I have received information about my condition and proposed chiropractic treatment program as well as alternative course of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment. I understand that, as in all health care, in the practice of chiropractic, while very rare, there are some risks to treatment. Risks include, but not limited to, muscle strain, ache, sprain, fracture, dislocation and stroke. I wish to rely on the doctor to exercise judgment during the course of the treatments based upon the facts then known, that is in my best interest.

My doctor has responded to all of my requests for information about the proposed treatment. I have read the above consent and by signing below I have consented to treatment.

____

Patient's Name (Printed)   Patient's Signature   Date

____

Parent/Guardian Name (Printed)   Parent/Guardian Signature   Date

____

Witness' Name (Printed)   Witness' Signature   Date