Neuro-Rehab Personal Information

& Health History Form

Thank you for choosing Big Creek Chiropractic & Nutrition, PLLC for your nutritional needs. To ensure maximum benefit of nutritional therapy, it is important that your information is accurate and up-to-date. If you notice any changes to your health, begin taking new prescriptions, etc.; please notify our office as soon as possible. It is also your right as a client to access updates or deletions from your records at any time. We are a HIPAA regulated entity, we are committed to protecting client privacy and following best practices laid out in the U.S Standards for Privacy of individually identifiable health information.

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| Name |  | **Date** |  |
| **Mailing Address** |  |
|  | **City** |  | **State** |  | **Zip** |  |
| **Phone Number** |  |
| **Email Address** |  |
| **Date of Birth** |  | **Sex** |  |
| **Weight** |  | **Height**  |  |
| **Occupation** |  | **Dominant hand**  |  |
| **Primary** **Concern**  |  |
|  |
| **Referred by** |  |
|  |
| **Primary Physician’s Name** |  |
| **Emergency Contact Name** |  | **Emergency Contact Number** |  |

**Medication/Vitamins**

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| Please list all current medication (with dosage):  |
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| Please list all current vitamins or supplements:  |
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Health History

Check only those conditions that are applicable.

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|  | **AIDS/HIV** |  | **Cataracts** |  | **Hepatitis** |  | **Mumps** |  | **Stroke** |
|  | **Alcoholism** |  | **Drug Dependency** |  | **Hernia** |  | **Osteoporosis** |  | **Suicide Attempts** |
|  | **Allergy Shots** |  | **Chicken Pox** |  | **Herniated Disc** |  | **Pacemaker** |  | **Thyroid Problems** |
|  | **Anemia** |  | **Depression** |  | **Herpes** |  | **Parkinson’s Disease** |  | **Tonsillitis** |
|  | **Anorexia** |  | **Diabetes** |  | **High Cholesterol** |  | **Pinched Nerve** |  | **Tuberculosis** |
|  | **Appendicitis** |  | **Emphysema** |  | **Hypertension** |  | **Pneumonia** |  | **Tumors/Growths** |
|  | **Arthritis** |  | **Epilepsy** |  | **Kidney Disease** |  | **Polio** |  | **Typhoid Fever** |
|  | **Asthma** |  | **Fractures** |  | **Liver Disease** |  | **Prostate Problems** |  | **Ulcers** |
|  | **Bleeding Disorder** |  | **Glaucoma** |  | **Measles** |  | **Prosthesis** |  | **Vaginal Infections** |
|  | **Breast Lumps** |  | **Goiter** |  | **Migraine/ Headaches** |  | **Psychiatric Care** |  | **Venereal Disease** |
|  | **Bronchitis** |  | **Gonorrhea** |  | **Miscarriages** |  | **Rheumatoid Arthritis** |  | **Whooping Cough** |
|  | **Bulimia** |  | **Gout** |  | **Mononucleosis** |  | **Rheumatic Fever** |  | **Autoimmune disease’s**  |
|  | **Cancer** |  | **Heart Disease** |  | **Multiple Sclerosis** |  | **Scarlet Fever** |  | **Stigmatism**  |
|  | **Strep throat**  |  | **Thyroid issues** |  | **Gluten/ Dairy intolerance**  |  | **Infection (in the last six months)**  |  | **Hearing loss** |
|  | **Vertigo** |  | **Dyslexia**  |  | **ADD/ADHD** |  | **Learning Disabilities**  |  | **Tourette** |
|  | **Tics** |  | **OCD** |  | **Concussion** |  | **Traveled in last 6 months (International)** |  | **Other** |

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| Have you ever been in a car accident if so please describe?  |
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| Have you ever slipped and fell on you head or take impact to the head other then a car accident  |
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**Disclaimer**

**Authorization and Permission Form regarding the use of Vision Vestibular Technology, Cold Laser, Muscle Testing, Other Physical Exam Tools, Instruments, or Outside Lab Testing**

I authorize, Big Creek Chiropractic & Nutrition to perform Vision Vestibular Technology, Cold Laser, Muscle Testing, Other Physical Exam Tools, Instruments, or Outside Lab Testing on me for the purpose of developing a program designed to improve my health and not for treatment or “cure” of any specific disease.

I understand that Vision Vestibular Technology, Cold Laser, Muscle Testing, Other Physical Exam Tools, Instruments, or Outside Lab Testing are safe and non-invasive methods of analyzing the nutritional and physical needs of the body. Deficiencies in these areas may cause or contribute to various health problems. I understand that EMI, Symptom Survey and Body Composition are not a method for diagnosis or treatment of any disease or other medical conditions, and that these are not being tested for or treated.

The results of the Vision Vestibular Technology, Cold Laser, Muscle Testing, Other Physical Exam Tools, Instruments, or Outside Lab Testing or any natural health, nutritional or dietary programs recommended are not guaranteed and no promises have been made regarding them. I understand that EMI, Muscle Testing, and Symptom Survey, Urinalysis can be used as an aid to determine possible nutritional imbalances, so that safe, natural programs can be recommended for the purpose of bringing about a more optimal state of health.

Vitamins, minerals, amino acids, herbs, and homeopathic remedies are not drugs. According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g) (1), the term “DRUG” is defined to mean: *“Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”* Although vitamins, minerals, amino acids, herbs, and homeopathic remedies may have an effect on any disease process or symptom, this does not mean it can be misrepresented or classified as a drug. Therefore, please be advised that any nutritional or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular body symptom. If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapy Practitioner is not a substitute for your physician or other appropriate healthcare provider and is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases or prescribe medications. If you are taken medications, it is important that you contact your other healthcare providers and alert them to your use of supplements and/or dietary changes. If any medical changes occur such as prescription changes, discuss them with the Nutritional Therapy Practitioner, however, any interactions will need to be determined by your pharmacist or healthcare provider.

I have **read and understand** the foregoing and this permission form also applies to subsequent visits and consultations.

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| Signature | Date |