**All In One**
**Dr Pamela A Buss**
509 E 6th st
Huntingburg, IN 47542
(812) 683-2273

# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential.
We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
◯ No ◯ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY)

Marital Status
◯ Single ◯ Married ◯ Divorced
◯ Widowed ◯ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
◯ Yes ◯ No

Address

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

**1. The symptom(s) that have prompted me to seek care today include:** _____

_____

**Patient name** _____

**2. And are the result of (darken circle):** ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

**3. Onset** (When did you first notice your current symptoms?)

_____

**4. Intensity** (How extreme are your current symptoms?)

0 ◯—◯—◯—◯—◯—◯—◯—◯—◯—◯—◯ 10
Absent Uncomfortable Agonizing

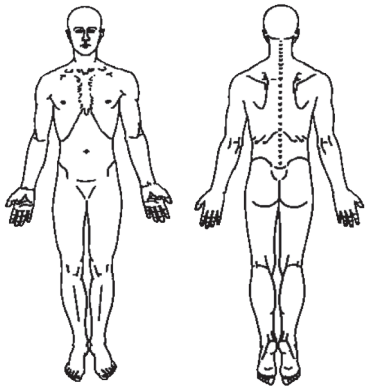
**5. Duration and Timing** (When did it start and how often do you feel it?)
◯ Constant ◯ Come and goes. How Often? _____

_____

**6. Quality of symptoms** (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

**7. Location** (Where does it hurt?)
Circle the area (s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



**8. Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

**9. Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

**10. Prior interventions** (What have you done to relieve the symptons?)

◯ Prescription medication ◯ Surgery ◯ Other _____
◯ Over-the-counter drugs ◯ Acupuncture _____
◯ Homeopathic remedies ◯ Chiropractic _____
◯ Physical therapy ◯ Massage

**11. What else should Dr. Buss know about your current condition?** _____

_____

**12. How does your current condition interfere with your:**

**Work or career:** _____

**Recreational activities:** _____

**Household resposibilities:** _____

**Personal relationships:** _____

**13. Review of Systems**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

**a. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Osteoporosis | ◯ | ◯ | Arthritis | ◯ | ◯ | Scoliosis | ◯ | ◯ | Neck pain | ◯ | ◯ | Back problems | ◯ | ◯ | Hip disorders |
| ◯ | ◯ | Knee injuries | ◯ | ◯ | Foot/ankle pain | ◯ | ◯ | Shoulder problems | ◯ | ◯ | Elbow/wrist pain | ◯ | ◯ | TMJ issues | ◯ | ◯ | Poor posture |

NONE ◯ Initials ____

**b. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anxiety | ◯ | ◯ | Depression | ◯ | ◯ | Headache | ◯ | ◯ | Dizziness | ◯ | ◯ | Pins and needles | ◯ | ◯ | Numbness |

NONE ◯ Initials ____

**c. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | High blood pressure | ◯ | ◯ | Low blood pressure | ◯ | ◯ | High cholesterol | ◯ | ◯ | Poor circulation | ◯ | ◯ | Angina | ◯ | ◯ | Excessive bruising |

NONE ◯ Initials ____

**d. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Asthma | ◯ | ◯ | Apnea | ◯ | ◯ | Emphysema | ◯ | ◯ | Hay fever | ◯ | ◯ | Shortness of breath | ◯ | ◯ | Pneumonia |

NONE ◯ Initials ____

**e. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anorexia/bulimia | ◯ | ◯ | Ulcer | ◯ | ◯ | Food sensitivities | ◯ | ◯ | Heartburn | ◯ | ◯ | Constipation | ◯ | ◯ | Diarrhea |

NONE ◯ Initials ____

**f. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Blurred vision | ◯ | ◯ | Ringing in ears | ◯ | ◯ | Hearing loss | ◯ | ◯ | Chronic ear infection | ◯ | ◯ | Loss of smell | ◯ | ◯ | Loss of taste |

NONE ◯ Initials ____

**g. Integumentary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Skin cancer | ◯ | ◯ | Psoriasis | ◯ | ◯ | Eczema | ◯ | ◯ | Acne | ◯ | ◯ | Hair loss | ◯ | ◯ | Rash |

NONE ◯ Initials ____

*Consultation Notes*

**Doctor's Initials** _____

**All In One**
**Dr Pamela A Buss**

*(Contiued from previous page)*

**h. Endocrine**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Thyroid issues | ○ | ○ | Immune disorders | ○ | ○ | Hypoglycemia | ○ | ○ | Frequent infection | ○ | ○ | Swollen glands | ○ | ○ | Low energy | Initials ____ |

**i. Genitourinary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Kidney stones | ○ | ○ | Infertility | ○ | ○ | Bedwetting | ○ | ○ | Prostate issues | ○ | ○ | Erectile dysfunction | ○ | ○ | PMS symptoms | Initials ____ |

**j. Constitutional**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Fainting | ○ | ○ | Low libido | ○ | ○ | Poor appetite | ○ | ○ | Fatigue | ○ | ○ | Sudden weight change | ○ | ○ | Weakness | Initials ____ |

**Patient name**

○ All other systems negative

## Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

### 14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| ○ | ○ | AIDS | ○ | ○ | Sexually transmitted disease |
| ○ | ○ | Alcoholism | ○ | ○ | Stroke |
| ○ | ○ | Allergies | ○ | ○ | Tuberculosis |
| ○ | ○ | Arteriosclerosis | ○ | ○ | Typhoid fever |
| ○ | ○ | Arthritis | ○ | ○ | Ulcer |
| ○ | ○ | Cancer | ○ | ○ | Other: _____ |
| ○ | ○ | Chicken pox | | | |
| ○ | ○ | Diabetes | | | |
| ○ | ○ | Eczema | | | |
| ○ | ○ | Emphysema | | | |
| ○ | ○ | Epilepsy | | | |
| ○ | ○ | Glaucoma | | | |
| ○ | ○ | Goiter | | | |
| ○ | ○ | Gout | | | |
| ○ | ○ | Heart disease | | | |
| ○ | ○ | Hepatitis | | | |
| ○ | ○ | Malaria | | | |
| ○ | ○ | Measles | | | |
| ○ | ○ | Multiple Sclerosis | | | |
| ○ | ○ | Mumps | | | |
| ○ | ○ | Pneumonia | | | |
| ○ | ○ | Polio | | | |
| ○ | ○ | Rheumatic fever | | | |
| ○ | ○ | Scarlet fever | | | |

### 15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

### 16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

| Past | Currently | |
|---|---|---|
| ○ | ○ | Acupuncture |
| ○ | ○ | Antibiotics |
| ○ | ○ | Birth control pills |
| ○ | ○ | Blood transfusions |
| ○ | ○ | Chemotherapy |
| ○ | ○ | Chiropractic care |
| ○ | ○ | Dialysis |
| ○ | ○ | Herbs |
| ○ | ○ | Homeopathy |
| ○ | ○ | Hormone replacement |
| ○ | ○ | Inhaler |
| ○ | ○ | Massage therapy |
| ○ | ○ | Physical therapy |
| ○ | ○ | Nutritional Supplements |
| ○ | ○ | Medications (prescription and over-the-counter): |

### 17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

*Consultation Notes*

### 18. Family History

Some health issues are hereditary. Tell Dr. Buss about the health of your immediate family members.

FAMILY

| Relative | Age (If living) | State of health | | Illnesses | Age at death | Cause of death | |
|---|---|---|---|---|---|---|---|
| | | Good | Poor | | | Natural | Illness |
| Mother | | ○ | ○ | | | ○ | ○ |
| Father | | ○ | ○ | | | ○ | ○ |
| Sister 1 | | ○ | ○ | | | ○ | ○ |
| Sister 2 | | ○ | ○ | | | ○ | ○ |
| Brother 1 | | ○ | ○ | | | ○ | ○ |
| Brother 2 | | ○ | ○ | | | ○ | ○ |
| _____ | | ○ | ○ | | | ○ | ○ |

**19. Are there any other hereditary health issues that you know about?** _____

### 20. Social History

Tell Dr. Buss about your health habits and stress levels.

SOCIAL

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ○ Daily | ○ Weekly | How much? _____ | Prayer or meditation? | ○ Yes | ○ No |
| Coffee use | ○ Daily | ○ Weekly | How much? _____ | Job pressure/stress? | ○ Yes | ○ No |
| Tobacco use | ○ Daily | ○ Weekly | How much? _____ | Financial peace? | ○ Yes | ○ No |
| Exercising | ○ Daily | ○ Weekly | How much? _____ | Vaccinated? | ○ Yes | ○ No |
| Pain relievers | ○ Daily | ○ Weekly | How much? _____ | Mercury fillings? | ○ Yes | ○ No |
| Soft drinks | ○ Daily | ○ Weekly | How much? _____ | Recreational drugs? | ○ Yes | ○ No |
| Water intake | ○ Daily | ○ Weekly | How much? _____ | | | |

Hobbies: _____

**Doctor's Initials**

**All In One**
**Dr Pamela A Buss**

**21. Activities of Daily Living**
How does this condition currently interfere with your life and ability to function?

| | No Affect | Mild Affect | Moderate Affect | Severe Affect |
|---|---|---|---|---|
| Sitting | ○ | ○ | ○ | ○ |
| Rising out of chair | ○ | ○ | ○ | ○ |
| Standing | ○ | ○ | ○ | ○ |
| Walking | ○ | ○ | ○ | ○ |
| Lying down | ○ | ○ | ○ | ○ |
| Bending over | ○ | ○ | ○ | ○ |
| Climbing stairs | ○ | ○ | ○ | ○ |
| Using a computer | ○ | ○ | ○ | ○ |
| Getting in/out of car | ○ | ○ | ○ | ○ |
| Driving a car | ○ | ○ | ○ | ○ |
| Looking over shoulder | ○ | ○ | ○ | ○ |
| Caring for family | ○ | ○ | ○ | ○ |

| | No Affect | Mild Affect | Moderate Affect | Severe Affect |
|---|---|---|---|---|
| Grocery shopping | ○ | ○ | ○ | ○ |
| Household chores | ○ | ○ | ○ | ○ |
| Lifting objects | ○ | ○ | ○ | ○ |
| Reaching overhead | ○ | ○ | ○ | ○ |
| Showering or bathing | ○ | ○ | ○ | ○ |
| Dressing myself | ○ | ○ | ○ | ○ |
| Love life | ○ | ○ | ○ | ○ |
| Getting to sleep | ○ | ○ | ○ | ○ |
| Staying asleep | ○ | ○ | ○ | ○ |
| Concentrating | ○ | ○ | ○ | ○ |
| Exercising | ○ | ○ | ○ | ○ |
| Yard work | ○ | ○ | ○ | ○ |

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

**Acknowledgements**
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **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 art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the 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.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called 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.**

Initials ____ **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.**

Initials ____ **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.**

**If the patient is a minor child, print child's full name:** _____

Signature _____ Date (MM/DD/YYYY) _____

**Patient name** _____

*Consultation Notes*

**Doctor's Initials** _____

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