NATURAL PAIN MANAGEMENT AND WELLNESS

2316-2318 Wehrle Drive Williamsville, NY 14221
Dr. Kristen Latona-Brzezinski

Name_____Date_____
Insurance:_____ ☐Male ☐Female
Address:_____ Marital Status
_____ S M W D SEP
Phone# Home:_____Work_____
Email_____
Occupation:_____ Employer:_____
Social Security #: _____DOB:_____

Mark C for Current problems , check and indicate the age when you had any of the following:

Check any conditions you have had / have:
☐alcoholism
☐alzheimer's
☐anemia
☐asthma
☐appendicitis
☐bronchitis
☐cancer
☐cataracts
☐cerebral palsy
☐chicken pox
☐cold sores
☐colitis
☐concussion
☐CRPS
☐CVA (stroke)
☐cystic cidney disease
☐depression
☐diabetes
☐eczema
☐emphysema
☐epilepsy
☐fibromyalgia
☐goiter
☐gout
☐heart disease
☐hepatitis
☐high cholesterol
☐HIV/ AIDS
☐influenza
☐liver disease
☐lung disease
☐lupus erythema
☐malaria
☐measles
☐multiple sclerosis
☐mumps
☐numbness/ tingling
☐osteoporosis
☐pacemaker
☐parkinson's disease
☐pleural effusion
☐eneumonia
☐polio
☐rheumatic fever
☐scoliosis
☐seizures
☐shingles
☐suicide attempt(s)
☐thyroid disease
☐tuberculosis
☐ulcers

Muscle/ Joint:
☐arthritis/ rheumatism
☐bursitis
☐foot trouble
☐muscle weakness
☐low back pain
☐mid back pain
☐neck pain
☐sprain/ strain
☐fracture

Skin:
☐psoriasis
☐boils
☐bruise easy
☐dryness / itching
☐hair loss
☐rash / hives
☐varicose veins

Gastrointestinal:
☐abdominal pain
☐bloody/ tarry stool
☐belching
☐crohns
☐constipation
☐diarrhea
☐difficult digestion
☐difficulty swallowing
☐excessive hunger
☐hernia
☐hemorrhoids
☐intestinal worms
☐indigestion
☐jaundice
☐liver trouble
☐loss of bowel control
☐nausea
☐painful defecation
☐pain over stomach
☐poor appetite
☐rectal bleeding
☐vomiting
☐vomiting blood

Allergies:
☐eggs ☐shellfish
☐soy ☐sulfa drugs
☐lactose ☐gluten
☐nut:_____
☐animal_____
☐environmental
_____
☐drugs:_____
_____
_____

Eye, Ear, Nose & Throat:
☐blind spots
☐colds
☐chronic ear infections
☐deafness
☐double vision
☐earache
☐ear discharge
☐eye pain
☐frequent sore throat
☐gum trouble
☐hoarseness
☐hearing loss
☐nasal obstruction
☐nasal congestion
☐nose bleeds
☐photophobia
☐loss sense of smell
☐ringing in ears
☐runny nose
☐sinus infection
☐sore throat
☐tonsillitis
☐vision problems
☐vertigo

Nervous System:
☐dizziness
☐facial weakness
☐limb weakness
☐loss of consciousness
☐memory loss
☐slurred speech
☐stress
☐unsteady gait
☐loss balance

Constitutional:
☐chills
☐daytime drossiness
☐fatigue
☐fainting
☐fever
☐loss of appetite
☐sleep disturbance
☐night sweats
☐weight gain/ loss
☐nervousness
☐dizziness
☐headaches
☐tremors

Cardiovascular:
☐claudication
☐high blood pressure
☐low blood pressure
☐hardening of the arteries
☐heart murmur
☐irregular pulse
☐orthopnea
☐pain over heart
☐palpitation
☐poor circulation
☐rapid heart beat
☐slow heart beat
☐swelling of ankles
☐shortness of breath
☐Raynaud's Disease

Respiratory:
☐chest pain
☐chronic cough
☐difficulty breathing
☐shortness of breath
☐hay fever
☐wheezing

Mark C for Current problems, check and indicate when you had any of the following:

Genitourinary:

- bed wetting
- bladder infection
- blood in urine
- kidney infection
- kidney stones
- prostate trouble
- pus in urine
- stress incontinence

Urination:

- overnight more than twice
- more than 8x in 24 hrs
- decreased flow/ force
- painful urination
- urgency to urinate

Sexual Health:

Do you have any concerns about your sexual health?_____

Are you or have you ever been a victim of domestic /sexual abuse? Yes No

Mental Health:

anxiety ADD/ADHD insomnia depression bipolar other_____

memory Loss mood change behavioral change

Do you have pets? If so what? _____

Women Only:

congested breasts vaginal discharge menopause

hot flashes cramps lumps in breasts

hormone therapy_____

Birth control_____

I… am currently pregnant am not currently pregnant

If you have been pregnant in the past, please fill in the appropriate information:

____ number of complicated pregnancies ____ number of uncomplicated pregnancies

____ number of C-Sections ____ number of vaginal deliveries

____ number of miscarriages ____ number of terminated pregnancies

Chief Complaint:

Give a brief description of the problem/ problems you are having:_____

_____

Please describe the pain you feel (i.e. burning, aching, stabbing, etc)_____

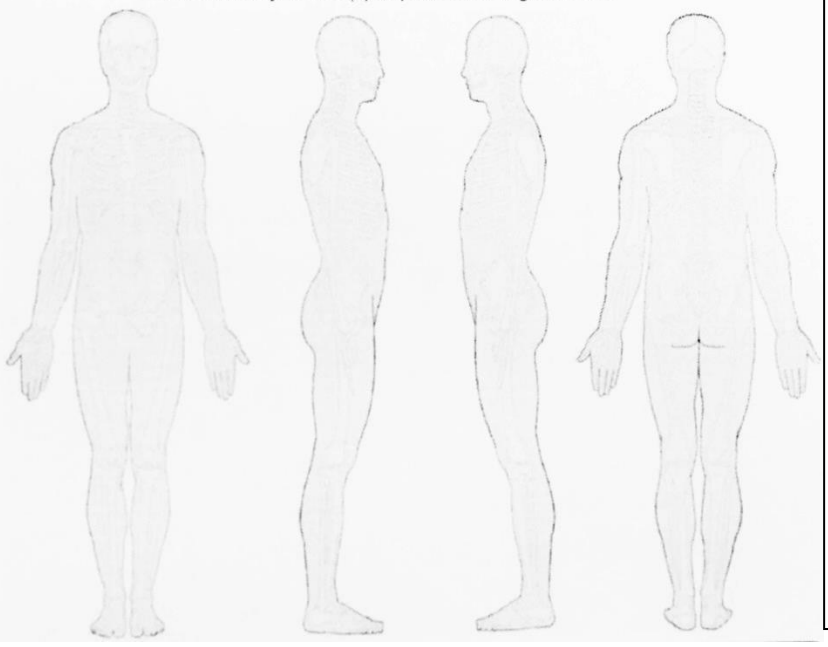
How often do you experience the pain?_____

When did this condition begin?_____ Is the pain getting Better Worse

What seemed to be the initial cause? _____

Please place a mark at the level of your pain on the scale below:

Please mark you area(s) of pain on the figure below



Habits:

	None	light	mod	heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Sodas				
Salt				
Water				
Sugar				

Interest in quitting

Smoking? Yes no

Chief Complaint..

Past health History

Have you…	Yes	No	Explain if Yes
…been hospitalized in the past 5 years?	☐	☐	_____
…had any broken bones?	☐	☐	_____
…had any sprains/ strains?	☐	☐	_____
….ever used orthotics?	☐	☐	_____

Do you take minerals, herbs, vitamins?_____

How is most of your day spent? ☐Standing ☐sitting ☐ other _____

Last physical exam?_____

Any other health concerns our staff should be aware of?

Family History: indicate who

☐Alcoholism	☐ Glaucoma
☐Anemia	☐Heart Disease
☐Arteriosclerosis	☐High Blood Pressure
☐Arthritis	☐High Cholesterol
☐Asthma	☐Multiple Sclerosis
☐Bleed easily	☐Osteoporosis
☐Cancer	☐ Stroke
☐Diabetes	☐Thyroid Disease
☐Emphysema	☐ Other _____
☐Epilepsy	_____

What are your goals you hope to achieve through treatment?_____

_____

What limitations if any, do you have in working with the doctors in this office toward achieving your treatment goals? (ie physical limitations, averse to life style changes, etc) _____

How did you hear of Natural Pain Management and Wellness? Referral (by Whom) _____

Advertisement Direct mailing Search Media (phonebook/ online) Other:_____

Thank you for providing us with this information so that we may provide you with the best medical care possible!

Signature: _____ **Date**:_____

Informed Consent

I herby request and consent to their performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor named below and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and or with other office/ clinical personel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, dislocations, disc injuries, strokes and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have read to me the above consent. I also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ **Date** : _____

Doctor Signature :_____ Date: _____