



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 kidney 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
- pneumonia
- 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
- 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
- facial weakness
- limb weakness
- loss of consciousness
- memory loss
- slurred speech
- stress
- unsteady gait
- loss balance

**Constitutional:**

- chills
- daytime drowsiness
- fatigue
- fainting
- fever
- loss of appetite
- sleep disturbance
- night sweats
- weight gain/ loss
- nervousness
- dizziness
- headaches
- tremors
- 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
- 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) \_\_\_\_\_

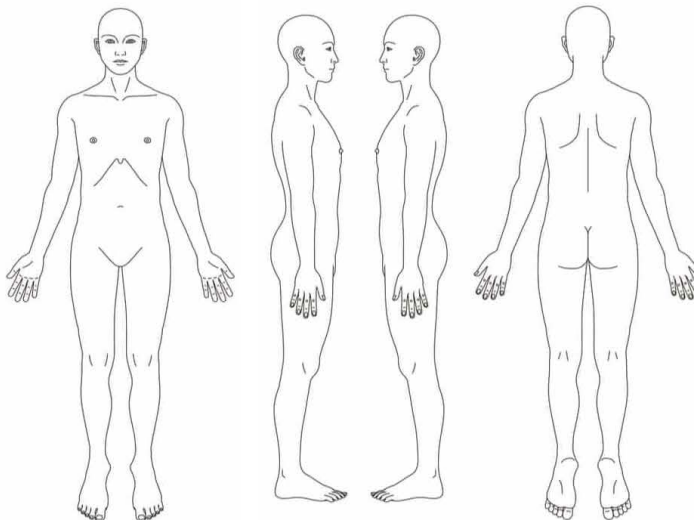
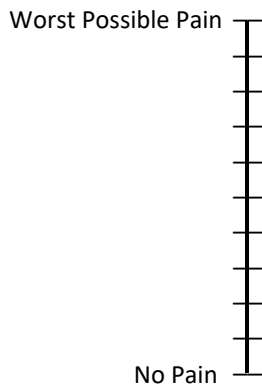
How often do you experience the pain? \_\_\_\_\_

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

What seemed to be the initial cause? \_\_\_\_\_

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

Please place a mark at the level of your pain on the scale 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? \_\_\_\_\_

**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 \_\_\_\_\_Any other health concerns our staff should be aware of?  
\_\_\_\_\_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) \_\_\_\_\_  
\_\_\_\_\_**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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 hereby 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: \_\_\_\_\_