Dr. Laura Barry
Chiropractic Healing Arts
120 Pleasant Hill Ave. Suite 170
Sebastopol, CA 95472
707 889-0995

Last Name: _____First Name: _____MI: __

Street Address/PO Box _____

City: _____ State: _____ Zip: _____

Mobile #: _____ Text Okay? Y N

Landline #: _____

E-Mail: _____

Date Of Birth _____

Time and Place if you know it _____
(*Occasionally we use Ayurvedic Astrologic remedies for difficult issues. It can be very helpful.*)

Employer: _____

Place of Employment: _____

Emergency Contact Person: _____

Phone #: _____

Referred By: _____

CHARGES ARE DUE & PAYABLE AT THE TIME SERVICE IS RENDERED
(24-HOUR NOTICE REQUIRED FOR CANCELLATIONS)

Dr. Laura Barry

PATIENT HISTORY

NAME: DATE:

HEIGHT: WEIGHT: IDEAL WEIGHT:

Occupation/Brief description of duties:

Major Accidents: (Please state when and nature of)

Surgeries & Hospitalizations: (Please state when, where & reason for)

Major illnesses, diseases, chronic conditions (E.G hay fever, sinuses, poor digestion, etc.)

Illnesses/diseases of close relatives: (E.G. Mother – heart disease & high blood pressure)

Current Medications:

Supplements:

Chief Complaint:

Other Complaints:

IMPORTANT: Please check all present symptoms. Name: _____ Date:_____

HEAD:
__Headache
__Sinus (allergy)
__ Entire head
__Back of head
__Forehead
__Temples
__Migraine
__Head feels heavy
__Loss of memory
__Light headedness
__Fainting
__Light bothers eyes
__Blurred vision
__Double vision
__Loss of vision
__Loss of taste
__Loss of balance
__Dizziness
__Los of hearing
__Pain in ears
__Ringing in ears
__Buzzing in ears

NECK:
__Pain in neck
__ Pain with movement
__Forward
__Backward
__Turn to left
__Turn to right
__Bend to left
__Bend to right
__Pinched nerve in neck
__Neck feels out of place
__Muscle spasms in neck
__Grinding sounds in neck
__Popping sounds in neck
__Arthritis in neck

SHOULDERS:
__Pain in shoulder joint (R__L__)
__Pain across shoulders
__Bursitis (R__L__)
__Arthritis (R__L__)
__Can't raise arm
__Above shoulder level
__Over-head
__Tension in shoulders
__Muscle spasms in shoulders

ARMS & HANDS:
__Pain in upper arm
__Pain in elbow
__Movement aggravated
__Tennis elbow
__Pain in forearm
__Pain in hands
__Pain in fingers
__Sensation of needles in arms
__Sensation of needles in fingers
__Numbness in arms(R__L__)
__Numbness in fingers(R__L__)
__Fingers go to sleep
__Hands cold
__Swollen joints in fingers
__Sore joints in fingers
__Arthritis in fingers
__Loss of grip strength

MID-BACK:
__Location_____
__Pain between shoulder blades
__Sharp stabbing
__Dull Ache
__Pain from front to back
__Muscle spasms
__Pain in kidney area

CHEST:
__Shortness of breath
__Pain around ribs
__Breast pain
__Dimpled or orange peel breast
__Irregular heart beat

ABDOMEN:
__Nervous stomach
__Foods cannot eat_____
__Nausea
__Gas
__Constipation
__Diarrhea
__Hemorrhoids

LOW BACK:
__Upper Lumbar
__Lower lumbar
__Sacroiliac
__Low back pain is worse when:
__Working
__Stooping
__Standing
__Sitting
__Sitting
__Bending
__Coughing
__Lying down:sleeping
__Walking
__Pain relieves when__
__Slipped disk
__Low back feels out
__Muscle spasms
__Arthritis

HIPS, LEGS & FEET:
__Pain/buttocks (R_L_)
__Hip Joint (R__L__)
__Down Leg(R__L__)
__Down both Legs
__Knee Pain
Inside_/Out_
__Leg Cramps
__Cramps/feet(R_L_)
__Pins&need. In legs
__Numbness /leg (R/L)
__Numbness/feet (R/L)
__Numbness/toes (R/L)
__Feet feel cold
__Swollen ankles
__Swollen feet

WOMEN ONLY:
__Menstrual pain: when
__Cramping Discharge
__Color
__Irregular_cycle_days
__Birth Control_Type
__Hysterectomy
__Genital Cancer
__Tumors
__Abortions
__Menopause

MEN ONLY:
__Urinary frequency
__Difficulty in starting
__Night urination
__Prostate pain/swelling

GENERAL:
__Nervousness/fatigue
__Depressed
__Sleep __hrs/night
__Loss/Gain weight__lbs.
__Coffee/tea__cups/day
__Cigarettes__pack/day
__Diabetes

Pain Drawing

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

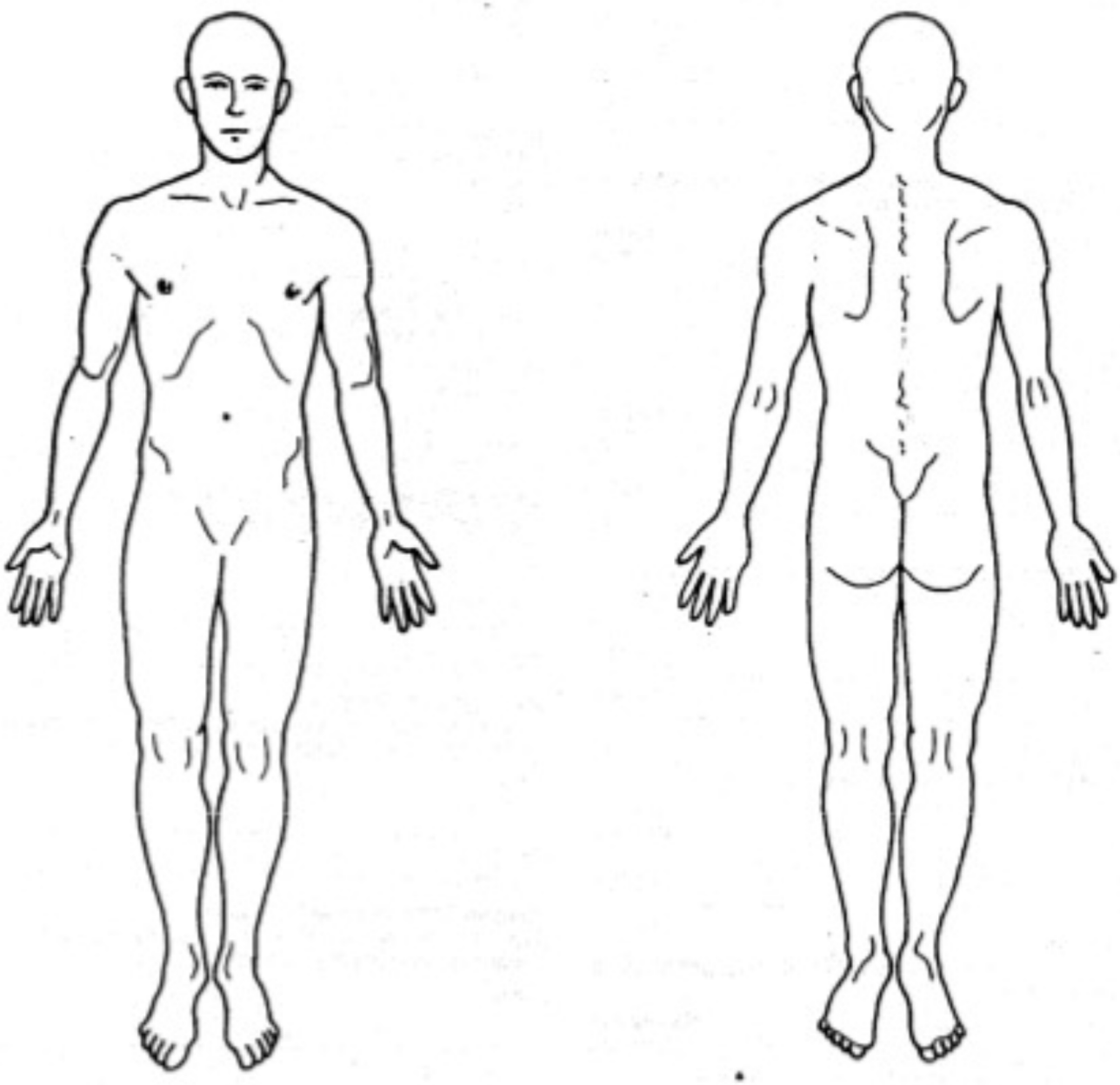
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



Dr. Laura Barry

Patient Goals:

As a new patient we would like to welcome you and to take care of you in the best way possible. Below you will find a short list of questions to help us determine your health care goals. Thank you.

Have you ever been treated by a chiropractor before? Yes No

If yes: **Since** when and how often?

Last Treatment?

Was it a good experience?

Do you like getting adjusted? Is there any kind of adjusting you prefer?

Do you receive regular bodywork? What kind?

Have you ever been rolfed or received connective tissue release work?

Are you here today to receive support in leading a holistic and wellness lifestyle or for symptomatic relief? Please Circle: Wellness or Relief Care

Do you exercise? How often? Light Moderate Heavy

Do you stretch before or after exercising? Before After Both

How many minutes on average do you exercise for?

How much water do you drink in a day?

Are you aware of how nutrition can support healthy aging?

Have you ever fasted? Please Circle:

Water Juice Other:

Do you have a stress management practice? Yoga Meditate Cardio
Other:

I hereby request and consent to the performance of chiropractic adjustments (non-force or diversified) and other chiropractic procedures, including myofascial release work, cranial suture release work, cranio-sacral balancing, muscle testing, vibracussion, SUMMUS Medical Laser provided by Dr. Laura Barry.

I have had an opportunity to discuss with Dr. Laura Barry and/or her office manager, the nature and purpose of chiropractic adjustments and other procedures. I understand that 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, disc injuries, strokes, dislocations 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 judgment 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 am also informed that therapeutic **SUMMUS Medical Laser** treatments are extremely safe when applied by a SUMMUS Medical Laser certified, properly trained professional. I understand that, in the clearing of inflammation from the body, proper hydration is necessary. I also understand that SUMMUS Medical Laser treatment is safe to deliver directly over metal implants, over broken skin, and on acute injuries.

Signed _____ Witness_____

Date _____

Financial Agreement
with the office of Dr. Laura Barry

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would first like to explain how your medical bills would be handled.

Is is our policy to maintain your account on a current basis.
Charges for treatment and supplies are due at the time they are provided.

As a courtesy, if you have health insurance coverage, we will provide you with "Super Bills" (receipts) to submit to your insurance company. Based on the terms of your policy, you will be reimbursed directly by your insurance carrier for your treatments.

In cases of personal injury claims that are not covered by "med pay" insurance, this office asks that you pay for your current treatment. The insurance company at the conclusion of your claim will reimburse you.

We ask that you give us at least 24 hours notice when you wish to cancel or reschedule an appointment, as this allows us to schedule someone else for that time. *Your account will be charged for missed appointments without sufficient notice.* We must adhere to this policy strictly because we wish to be able to see everyone who needs our care.

Once again, we would like to welcome you to our office.

If you have any questions at ay time, please feel free to ask us.

Your signature below confirms that you have read and agreed to the above terms.

Signature: _____

Date: _____