

Patient Information

Name: _____ Referred by: _____
Home Phone: _____ Emergency Contact 1: _____
Cell: _____ Emergency Contact Phone: _____
Address: _____ Emergency Contact 2: _____
City: _____ Emergency Contact Phone: _____
State: _____ Who is responsible for payment of this bill?
Zip: _____ You Auto/Accident Insurance
Birth Date: _____ Insured Person's Name: _____
Personal Email: _____ Insured's Date of Birth: _____
Business Phone: _____

Patient Requested:

1) Traditional Chiropractic: _____ Yes _____ No

Relief Care: Yes No

Corrective Care: Yes No

What is Relief Care?

This care attempts to rid you or your symptoms or pain. It does not address the cause of the condition.

What is Corrective Care?

This care has the goal of correcting the underlying cause of the symptoms, pain or condition.

2) Holistic Health Therapies: _____ Yes _____ No

By signing this form, you are consenting to consultation, examination and treatment procedures used by Dr. Gertler. These procedures employ both standard chiropractic methods and alternative methods and protocols. I understand that results are not guaranteed, and am informed that in the practice of holistic chiropractic, as in the practice of medicine, there are some risks, including, but not limited to, sprain/strain, Charlie horse, and allergic reactions. I acknowledge receipt of this disclosure.

Signature: _____ Date: _____

Center for Holistic Health
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Center for Holistic Health
HISTORY OF COMPLAINT FORMS

List the 5 major health concerns in order of importance:

Chief complaint #1 _____

Chief complaint #2 _____

Chief complaint #3 _____

Chief complaint #4 _____

Chief complaint #5 _____

Details of Your Chief Complaints in the same order as you itemized them in the above section:

Chief Complaint #1:

1. When did you first experience the pain/discomfort? _____

2. Is the pain/discomfort mild, moderate or severe? (Circle One)

3. On a scale (10 being the most severe pain), rate your pain:

1 2 3 4 5 6 7 8 9 10

4. Is the pain constant or intermittent? _____

5. What makes the pain better? _____

6. Describe the type of pain/discomfort: dull throbbing sharp Other?: _____

(Circle one)

7. Is the pain/discomfort confined to a certain region, or does it radiate? _____

8. Have you received treatment for this complaint in the past? _____ Yes _____ No

If so, what kind of treatment? _____

Was this treatment successful? _____ Yes _____ No

Chief Complaint #2:

1. When did you first experience the pain/discomfort? _____

2. Is the pain/discomfort mild, moderate or severe? (Circle One)

3. On a scale (10 being the most severe pain), rate your pain:

1 2 3 4 5 6 7 8 9 10

4. Is the pain constant or intermittent? _____

5. What makes the pain better? _____

6. Describe the type of pain/discomfort: dull throbbing sharp Other?: _____

(Circle one)

7. Is the pain/discomfort confined to a certain region, or does it radiate? _____

8. Have you received treatment for this complaint in the past? _____ Yes _____ No

If so, what kind of treatment? _____

Was this treatment successful? _____ Yes _____ N

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Chief Complaint #3:

1. When did you first experience the pain/discomfort? _____
2. Is the pain/discomfort mild, moderate or severe? (Circle One)
3. On a scale (10 being the most severe pain), rate your pain:
1 2 3 4 5 6 7 8 9 10
4. Is the pain constant or intermittent? _____
5. What makes the pain better? _____
6. Describe the type of pain/discomfort: dull throbbing sharp Other?: _____
(Circle one)
7. Is the pain/discomfort confined to a certain region, or does it radiate? _____
8. Have you received treatment for this complaint in the past? _____ Yes _____ No
If so, what kind of treatment? _____
Was this treatment successful? _____ Yes _____ No

Chief Complaint #4:

1. When did you first experience the pain/discomfort? _____
2. Is the pain/discomfort mild, moderate or severe? (Circle One)
3. On a scale (10 being the most severe pain), rate your pain:
1 2 3 4 5 6 7 8 9 10
4. Is the pain constant or intermittent? _____
5. What makes the pain better? _____
6. Describe the type of pain/discomfort: dull throbbing sharp Other?: _____
(Circle one)
7. Is the pain/discomfort confined to a certain region, or does it radiate? _____
8. Have you received treatment for this complaint in the past? _____ Yes _____ No
If so, what kind of treatment? _____
Was this treatment successful? _____ Yes _____ No

Chief Complaint #5:

1. When did you first experience the pain/discomfort? _____
2. Is the pain/discomfort mild, moderate or severe? (Circle One)
3. On a scale (10 being the most severe pain), rate your pain:
1 2 3 4 5 6 7 8 9 10
4. Is the pain constant or intermittent? _____
5. What makes the pain better? _____
6. Describe the type of pain/discomfort: dull throbbing sharp Other?: _____
(Circle one)
7. Is the pain/discomfort confined to a certain region, or does it radiate? _____
8. Have you received treatment for this complaint in the past? _____ Yes _____ No
If so, what kind of treatment? _____
Was this treatment successful? _____ Yes _____ No

On the diagram below, please draw in and label the 4 chief health complaints from Page 3. Draw the complaint in the exact same position as it relates to your body. Label each accordingly. For example, chief health complaint #1 would be labeled on the chart as CC#1, etc.

