

LUKE CHIROPRACTIC & SPORTS INJURY

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OUR PURPOSE STATEMENT

Our purpose is to educate & treat as many families as possible about the spinal condition called Vertebral Subluxation; for it is Vertebral Subluxation that destroys an Optimal Spine and destroys Optimal Health. Therefore, we look forward towards your experience in this office as for healing & full function of your nervous system & body, & learning the TRUTH about health.

PATIENT HEALTH HISTORY

DATE: ____/____/____

NAME: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: M F

MARITAL STATUS: (check one) () SINGLE () MARRIED () DIVORCED () WIDOWED

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: () _____ WORK PHONE: () _____ ext. _____

CELL PHONE: () _____ PAGER #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

SPOUSE'S NAME: _____

CHILDREN'S NAME(S) & AGE(S): _____

REFERRED TO OUR OFFICE BY: _____

LAST DATE SEEN BY CHIROPRACTOR: _____ DR. _____

REASON YOU CAME TO OUR OFFICE: _____

IF YOU WERE INJURED, WAS IT ... (Circle One) WORK AUTO PERSONAL
DID YOU CONTACT YOUR EMPLOYER? YES NO
FOR FEMALES: ARE YOU PREGNANT? YES NO

(PLEASE NOTIFY THE DOCTOR IF YOU ARE PREGNANT OR POSSIBLY PREGNANT)

The vast majority of our patients have been involved in dozens of impacts that could cause **VERTEBRAL SUBLUXATION**; the doctor wants to discover FIVE of yours.

1. When was your MOST recent Auto Accident? Date: _____

◆ Speed? ____ mph (Please Circle) FRONT BACK SIDE OTHER: _____

◆ Any treatment received? YES/NO _____

◆ Chiropractic care? YES/NO _____

2. When was the one before that? Date: _____

◆ Speed? ____ mph (Please Circle) FRONT BACK SIDE OTHER: _____

◆ Any treatment received? YES/NO _____

◆ Chiropractic Care? YES/NO _____

3. Any others, even if you were not the driver of vehicle? On a motorcycle? Date: _____

Most people have a slip, strain, twist, or fall playing **sports**, at **home**, or **work**, whether it was reported or not.

1. When was your most recent stress or strain? Date: _____

◆ Any treatment received? YES/NO _____

◆ Chiropractic care? YES/NO _____

2. When was the one before that? Date: _____

◆ Any treatment received? YES/NO _____

◆ Chiropractic care? YES/NO _____

3. When was the one before that? Date: _____

SOCIAL HABITS: ALCOHOL (bottle/week) _____ SODA (cans/day) _____
 COFFEE (cups/day) _____ TOBACCO (#/day) _____
 EXERCISE (times/week) _____ Type(s) _____
 RECREATIONAL DRUGS () None () Light () Moderate () Heavy

MEDICATIONS: _____

Vertebral Subluxation can put pressure on nerves for a long period of time			
How long have you had your symptoms? Please indicate in MONTHS or YEARS as to the first time you had your symptoms (example: Headache- 5 years ago, Allergies- 1992)			
ILLNESS	WHEN	ILLNESS	WHEN
HEADACHE/DIZZINESS		LEGPAIN	
NECK PAIN		NUMBNESS/TINGLING	
SHOULDER		NERVOUSNESS	
ARM/HAND PAIN		FA TIGUE	
ALLERGY		NEURITIS	
SINUS		THROAT PROBLEM	
UPPER/MID BACK PAIN		STIFFNESS	
LOW BACK PAIN		ASTHMA	
HIP PAIN		ULCER/DIGESTIVE PROBLEM	
DIA BETES		COLD HANDS/FEET	
MUSCLE CRAMPS		THROID	
MENSTRUAL DIFFICULTIES		LOW /HIGH BLOOD PRESSURE	
SURGERY		OTHER	

Do any of your family members have any of the symptoms above?

Name: _____ **Relationship:** _____ **Health Problems:** _____

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Name: _____ **Relationship:** _____ **Health Problems:** _____

CAN YOU SEE HOW THIS IS STARTING TO MAKE SENSE ABOUT VERTEBRAL SUBLUXATION?

1. Vertebral Subluxation can cause irritation to different nerve fibers, is your condition:

(Please Circle) **SHARP DULL THROBBING BURNING ACHING STABBING PAIN**

2. Depending on the type and the degree of Subluxation, the nerve pressure can be constant or

occasional. How often do you have yours? _____ *times a day* _____ *times a week* _____ *times a month*

Vertebral Subluxation can cause weakening to the entire spine. Is your condition worse?

(Please Circle) **In the A.M.** **In the P.M.** **Anytime** **After Activity**

X

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE