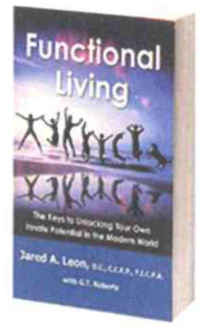
LEON Chiropractic
Dr. Jared Leon
213 Hallock Rd Suite 4B
Stony Brook, NY 11790
(631) 689-1000

"Functional Living: **The Keys to Unlocking Your Own Innate Potential in the Modern World" by Dr. Jared Leon** now available on Amazon and other retailers.



Name____

Address____

City/State/Zip ____________________________________

Phone #'s (home) __________________(cell) __________________

E-mail address____________________________________

Birthdate____________________Age____________________

Occupation____________________Employer__________________

Marital status __________________Spouse's name________________

Do you have any children?____________If yes, names and ages please__________

____

Favorite hobbies or interests ______________________________

Emergency contact: Name______________________________

Relationship____________________Phone #(s)__________________

What Brings You Here?

Is this appointment for you or another family member? ____________________

Has the patient ever had chiropractic care before?______________________

Was the patient pleased with the care and what were the results?________________

____

How did you find our office?______________________________

Is this appointment related to any of the following?

- Work
- Sports
- Auto
- Personal injury
- Other: ____________

When did the incident occur? ______________________________

Please list any drugs or medications you are taking ____________________

____

Please list any vitamins/herbs/homeopathics/other you are taking ________________

____

Pregnancy

Is the patient pregnant?________________________If yes, how many weeks?________________

Muscular Skeletal

Does the patient have pain in any of the following? Please check all that applies to the patient.

- Neck
- Sternum
- Shoulder Right/Left
- Arm Right/Left
- Elbow Right/Left
- Wrist Right/Left
- Upper Back
- Lower Back
- Hip/Sciatica Right/Left
- Knee Right/Left
- Ankle Right/Left
- Foot Right/left

Does the patient suffer or have ever been diagnosed with any of the following? Please check all that applies to the patient.

- Acid reflex
- Adrenal Fatigue
- Allergies
- Asthma
- Chronic cough
- Chronic infections
- Colitis
- Constipation
- Crohn's disease
- Epstein-Barr Virus
- Irritable Bowel
- Leaky Gut
- Lyme's disease
- Numbness/Tingling
  Body Part:________________________
  ____
- Sexual Dysfunction
- Sleep disorders

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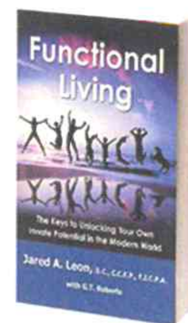

Neurological

Does the patient suffer from any of the following? Please check all that applies.

- ADD/ADHD
- Adrenal
- Alzheimer
- Anxiety
- Brain Fog
- Clumsiness
- Deadly thoughts
- Dementia
- Depression
- Dizzy
- Doubt
- Extremely judgmental
- Falling often
- Fatigue
- Fear
- Headaches
- Hearing loss
- High blood pressure
- High cholesterol
- Infertility sexual problems
- Learning disabilities
- Memory loss
- Migraines
- Moderate/severe stomach pain
- Motion sickness
- Multiple Sclerosis
- Organizational skills
- Parkinson
- Shaking/Tremors
- Shape discernment
- Stuttering
- Thyroid
- Tinnitus
- Trouble speaking
- Vertigo
- Worry

Does the patient use any of the following?

- Alcohol
- Cigarettes
- Coffee
- Drugs
- Fat Free foods or drinks
- Soda
- Sweeteners
- Sugar Free foods or drinks

On a scale from 1 to 10 with 1 being poor and 10 being excellent, please rate the following:

How positive are the patient's daily thoughts ____
How does the patient rate his/her daily nutrition ____
How does the patient rate his/her sleep____ How many hours sleep does he/she average daily _____
How does the patient rate his/her global lifestyle choices ____
How often does the patient engage in cardio exercise? ____________________
How often does the patient engage in strength exercise? ____________________
How often does the patient engage in stretching/yoga? ____________________
How often does the patient read? ____________________

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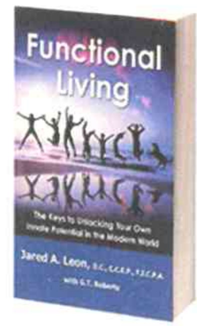

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the potential risks involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides Dr. Leon with your permission to perform reasonable and necessary functional chiropractic and/or functional neurological testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with Dr. Leon about the purpose, potential risks and benefits of all functional chiropractic and functional neurological treatment. If you have any concerns regarding any test or treatment recommend by Dr. Leon, we encourage you to ask questions. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Consent to Treatment:

Signature:____ **Date:**__________________

I only consent that I am here for muscular skeletal and choose to bypass a neurological exam.

Signature:____ **Date:**__________________