Patient Health History

Today's date ____ / ____ / ____

How did you hear about us?

- ❑ **INTERNET**
- ❑ Family _____
- ❑ Friend _____
- ❑ Co-worker _____
- ❑ Close to home/work
- ❑ Dr. _____
- ❑ Yellow Pages
- ❑ Drove by
- ❑ Hospital
- ❑ Insurance plan

Personal Information

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First name _____ **Nickname** _____

Last name _____ **Middle name** _____ **Suffix** _____

Social security number _____

Address 1 _____

Address 2 _____

City _____ **State** _____ **Zip Code** _____

Primary phone _____ **Secondary phone** _____

Mobile phone _____

Home e-mail _____ **Work e-mail** _____

By providing my e-mail address, I authorize my doctor to contact me via the e-mail address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*
❑ Primary phone ❑ Secondary phone ❑ Mobile phone ❑ Home e-mail ❑ Work e-mail

Date of birth _____ / _____ / _____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian/other Pacific Island
❑ Samoan	❑ Guamanian/Chamorro	❑Other	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

To be performed by clinic staff:

Height _____ inches **Weight** _____ pounds **BP** _____ / _____

Employment Information

Business Name _____

Address _____

City _____ **State** _____ **Zip** _____ **Country** _____ **County** _____

Phone _____ **Fax #** _____

Employer's E-mail Address _____

Occupation/Job Title _____ **Job Description** _____

Verification Question (*choose one question, then give the answer to that question on the line provided*)

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Answer (*must be 6 characters in length*) _____

Social History

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker ❑ Live with a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Smoke # _____ packs per ❑ day ❑ week ❑ month ❑ year

Chew # _____ cans per ❑ day ❑ week ❑ month ❑ year

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑ 8 ❑ 9 ❑ 10

No interest *Very interested*

Which of the following describes your alcohol consumption? ❑ Do not drink alcohol ❑ Social consumption only ❑ Drink regularly

Which of the following do you drink regularly? ❑ beer ❑ liquor ❑ wine

quantity: _____ oz/glasses per ❑ day ❑ week ❑ year

Substance abuse

❑ never used illegal drugs ❑ has not used illegal drugs since _____

❑ never used IV drugs ❑ used illegal drugs for _____ (how long?)

My dietary intake consists mainly of the following (*check all that apply*):

❑ high fat ❑ high salt ❑ low fiber
❑ high fiber ❑ low calorie ❑ low salt
❑ high protein ❑ low carbohydrate ❑ low sugar

Medications/Allergies

List any prescription medications you are currently taking, including dosage and frequency if known.
If you are not currently taking any prescription medications, please check here ❑.

	Name	Dosage	Frequency	Start Date
1)				
2)				
3)				
4)				
5)				

List any non-prescription items you are currently taking (vitamins, herbs, etc.)
If you are not currently taking any non-prescription items, please check here ❑.

1) _____ **4)** _____
2) _____ **5)** _____
3) _____

List any known allergies you have had to any medications below.
If no allergies to medications are known, please check here ❑.

1) _____ **4)** _____
2) _____ **5)** _____
3) _____

Has any doctor diagnosed you with high blood pressure presently? ❑ Yes ❑ No
If yes, describe: _____

Has any doctor diagnosed you with diabetes presently? ❑ Yes ❑ No
If yes, what kind? ❑ Type I ❑ Type II
If yes, was your blood/lab work test for hemoglobin A1c higher than 9.0%? ❑ Yes ❑ No ❑ Not sure
Other comments: _____

Have you had an x-ray or CT scan or MRI of your low back spine performed within the last 28 days? ❑ Yes ❑ No

Current Health Condition

Unwanted condition (*why are you here today?*) _____

When did this condition begin? _____ / _____ / _____

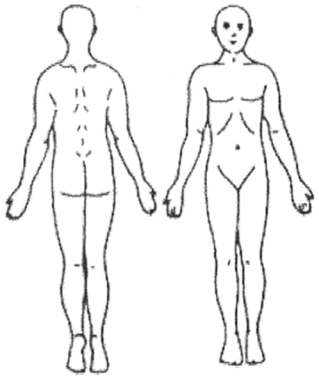
Has this condition ever occurred before? ❑ Yes ❑ No
If yes, when? _____

Is this condition related to any of the following?
❑ Auto-related ❑ Job-related ❑ Home injury ❑ Slip or fall ❑ Lifting
❑ Slept wrong ❑ Unknown cause ❑ Other _____

Do you suffer with any condition other than the one for which you are here today for?
_____

Please label on the figure below the area of discomfort using the letters below to indicate the type and location of your sensations right now.

Key:
A = ache
B = burning
N = numbness
P = pins and needles
S = stabbing



Previous care for this same condition

Have you previously seen a doctor for this condition? ❑ Yes ❑ No

If yes, please fill in the information below:

Doctor's name _____

Type of treatment _____

Were you satisfied with the results of your treatment? ❑ Yes ❑ No

If no, explain: _____

Have you previously seen a chiropractor for this condition? ❑ Yes ❑ No

If yes, please fill in the information below:

Doctor's name _____

Location _____

Date of last visit _____

Were you satisfied with your care? ❑ Yes ❑ No

If no, explain: _____

Do you wear any of the following?

❑ Heel lifts ❑ Innersoles ❑ Arch supports ❑ Orthotics ❑ Other _____

If yes, for how long? _____ Were they prescribed by a doctor? ❑ Yes ❑ No

Review of Systems (*Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.)*

Please circle the conditions you have had in the past twelve months. If none apply, circle NONE.

Constitutional:

chills, fatigue, night sweats, weight loss
daytime drowsiness, fever, weight gain, **NONE**

Eyes/Vision:

blindness, change in vision, field cuts, photophobia, tearing
blurred vision, cataracts, double vision, glaucoma, itching
glasses/contacts, eye pain, **NONE**

Ears/Nose/Throat:

bleeding, ear drainage, hearing loss, nose bleeds, sore throat
dentures, ear pain, history of head injury, postnasal drip, tinnitus
difficulty swallowing, fainting, hoarseness, TMJ problems, rhinorrhea (runny nose)
discharge, sinus infections, nasal congestion, frequent sore throats, loss of sense of smell
snoring, dizziness, headaches, **NONE**

Respiration:

asthma, coughing up blood, sputum production, cough, shortness of breath
wheezing, **NONE**

Cardiovascular:

angina (chest pain), high blood pressure, low blood pressure, shortness of breath, swelling of legs
claudication (leg pain), heart murmur, heart problems, orthopnea (difficulty breathing laying down)
varicose veins, palpitations, paroxylsmal nocturnal dyspnea (waking at night with shortness of breath)
NONE

Gastrointestinal:

abdominal pain, belching, black/tarry stools, constipation, diarrhea
difficulty swallowing, heartburn, hemorrhoids, indigestion, jaundice
nausea, rectal bleeding, abnormal stool caliber, abnormal stool color, vomiting blood
abnormal stool consistency, **NONE**

Female:

birth control, breast lumps/pain, burning urination, frequent urination, cramps
hormone therapy, pregnancy, irregular menstruation, urine retention, **NONE**

Male:

burning urination, frequent urination, prostate problems, urine retention, erectile dysfunction
hesitancy/dribbling, **NONE**

Endocrine:

cold intolerance	excessive hunger	goiter	unusual hair growth	diabetes
excessive thirst	hair loss	voice changes	excessive appetite	heat intolerance
abnormal frequency of urination		**NONE**		

Skin:

changes in nail texture	hair loss	itching	skin lesions/ulcers	changes in skin color
hives	paresthesias	varicosities	hair growth	rash
history of skin disorders		**NONE**		

Nervous System:

limb weakness	numbness	slurred speech	tremor	facial weakness
loss of consciousness	seizures	stress	loss of balance	headache
loss of memory	sleep disturbance	strokes	**NONE**	

Psychological:

anhedonia	behavioral change	convulsions	memory loss	anxiety
bi-polar disorder	depression	mood change	loss/change in appetite	confusion
insomnia	**NONE**			

Allergy:

anaphalaxis	itching	sneezing	chronic nasal congestion
food intolerance	rash	acute nasal congestion	**NONE**

Hematologic:

anemia	blood clotting	bruising easily	lymph node swelling	bleeding
blood transfusion	fatigue	**NONE**		

Childhood Illness(es) (*check all conditions that apply*)

❑ ADD	❑ chicken pox	❑ headaches	❑ scoliosis
❑ atopic dermatitis (eczema)	❑ crohn's/colitis	❑ hepatitis	❑ seizure disorder
❑ allergies/hay fever	❑ depression	❑ HIV	❑ sickle cell anemia
❑ anemia	❑ diabetes	❑ measles	❑ spina bifida
❑ asthma	❑ ear infections	❑ mumps	❑ other _____
❑ bedwetting	❑ fetal drug exposure	❑ psoriasis	
❑ cerebral palsy	❑ food allergies	❑ rash	

Adult Illness (es) (*check all conditions that apply*)

❑ ADD	❑ cystic kidney disease	❑ hypertension	❑ psychiatric problems
❑ Alzheimers	❑ depression	❑ influenza pneumonia	❑ scoliosis
❑ anemia	❑ diabetes (insulin dep)	❑ liver disease	❑ seizures
❑ arthritis	❑ diabetes (non insulin)	❑ lung disease	❑ shingles
❑ asthma	❑ eczema	❑ lupus erythema (discoid)	❑ past history of similar symptoms
❑ cancer	❑ emphysema	❑ lupus erythema (systemic)	❑ STD's (unspecified)
❑ cerebral palsy	❑ eye problems	❑ multiple sclerosis	❑ suicide attempt(s)
❑ chicken pox	❑ fibromyalgia	❑ parkinson's disease	❑ thyroid problems
❑ crohn's/colitis	❑ heart disease	❑ unspecified pleural effusion	❑ vertigo
❑ CRPS (RSD)	❑ hepatitis	❑ pneumonia	❑ other _____
❑ CVA (stroke)	❑ HIV	❑ psoriasis	

Do you believe that the adult illness (es) listed above are contributory to your current condition? ❑ Yes ❑ No

Surgery (ies) (*Check all surgical procedures you have undergone. Write the date of the procedure immediately afterward.*)

❑ angioplasty	❑ cosmetic	❑ hysterectomy	❑ pacemaker insertion
❑ appendectomy	❑ D&C	❑ joint reconstruction	❑ rotator cuff
❑ caesarian section	❑ dental surgery	❑ joint replacement	❑ spinal fusion
❑ cardiac catheterization	❑ gall bladder	❑ knee repair	❑ tonsilectomy
❑ carpal tunnel repair	❑ hemorrhoidectomy	❑ laminectomy	❑ other _____
❑ coronary artery bypass	❑ hernia repair	❑ mastectomy	

Injury (ies) (*Check all injuries. Write the date of the injury immediately afterward.*)

- ❑ back injury
- ❑ broken bones
- ❑ disability (ies)
- ❑ fall (severe)
- ❑ fracture
- ❑ head injury (loss of consciousness)
- ❑ head injury (no loss of consciousness)
- ❑ industrial accident
- ❑ joint injury
- ❑ laceration (severe)
- ❑ motor vehicle accident
- ❑ soft tissue injury (mild)
- ❑ soft tissue injury (moderate)
- ❑ soft tissue injury (severe)
- ❑ other _____

OB/GYN, females only (*check all that apply.*)

Are you currently pregnant? ❑ Yes ❑ No

If you have been pregnant in the past, please answer the following questions below:

____ number of complicated pregnancies
____ number of c-sections
____ number of miscarriages
____ number of uncomplicated pregnancies
____ number of vaginal deliveries
____ number of terminated pregnancies

Menstrual history:

____ age of first menses
____ age when metaphase began
Do you currently have menses? ❑ Yes ❑ No
My menses are: ❑ Regular ❑ Irregular
Date of last menses: ____ / ____ / ____

Immunizations (*Check all immunizations you have had. Write the date immediately after.*)

- ❑ adenovirus
- ❑ anthrax
- ❑ botulism
- ❑ diphtheria
- ❑ DTaP (diphtheria, tetanus, pertussis)
- ❑ flu
- ❑ haemophilus B
- ❑ hepatitis A
- ❑ hepatitis B
- ❑ hepatitis C
- ❑ influenza
- ❑ IPV (polio)
- ❑ Japanese encephalitis
- ❑ lyme disease
- ❑ measles
- ❑ meningococcal
- ❑ MMR
- ❑ mumps
- ❑ pertussis
- ❑ pneumococcal
- ❑ pneumovax
- ❑ PPD (mantoux test-TB)
- ❑ rabies
- ❑ rotavirus
- ❑ rubella
- ❑ smallpox
- ❑ tetanus
- ❑ tuberculosis
- ❑ tularemia
- ❑ typhoid
- ❑ varivax (chicken pox)
- ❑ yellow fever
- ❑ other _____

Non-drug Allergies (*check all that apply.*)

- ❑ adhesive tape
- ❑ animals
- ❑ bee sting
- ❑ chocolate
- ❑ dairy
- ❑ eggs
- ❑ feathers
- ❑ food coloring
- ❑ latex
- ❑ mold
- ❑ newsprint
- ❑ nuts
- ❑ peanuts
- ❑ perfumes
- ❑ pollen
- ❑ shellfish
- ❑ smoke
- ❑ soap
- ❑ soy
- ❑ wheat
- ❑ other _____

Label the number of the type of reaction you have to each allergy immediately after the allergy above.

1. angioedema
2. anaphylaxis
3. GI disturbance
4. headache
5. joint pain
6. rash
7. shortness of breath
8. unspecified reaction

Insurance Information

Who is responsible for your bill?

- ❑ Myself
- ❑ Spouse
- ❑ Worker's Comp.
- ❑ Auto insurance
- ❑ Medicare
- ❑ Medicaid
- ❑ Other _____

Personal health insurance carrier _____
Policy holder's name _____
Policy holder's SSN _____
Health ID card # _____
Group # _____
Primary care physician _____

Worker's Compensation Injury/Auto/Personal Injury

Have you filed an injury report with your employer? ❑ Yes ❑ No Date ___ / ___ / ___ Time _____ am/pm

Carrier _____ Policy # _____

Carrier's phone # _____ Adjuster _____ Claim # _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient print name _____ **Date** _____

Patient's signature _____ **Date** _____

Consent to treat a minor _____ **Date** _____

Guardian/spouse's signature of authorizing care _____ **Date** _____

Please list below the individual(s) you authorize to have access to your medical and billing records.

Name _____ **Relation** _____

Name _____ **Relation** _____

Name _____ **Relation** _____

Name _____ **Relation** _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health history information.

Patient print name _____ **Date** _____

Patient's signature _____ **Date** _____