

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 _____

 Employed
 FT Student
 PT Student
 Retired
 Self Employed
 Other
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?

Answer (must be 6 characters in length) _____

Social HistoryDo 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?

quantity: _____ oz/glasses per

 beer liquor wine 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) _____
- 2) _____
- 3) _____

- 4) _____
- 5) _____

List any known allergies you have had to any medications below.

If no allergies to medications are known, please check here .

- 1) _____
- 2) _____
- 3) _____

- 4) _____
- 5) _____

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

Briefly list your main health problem _____

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:

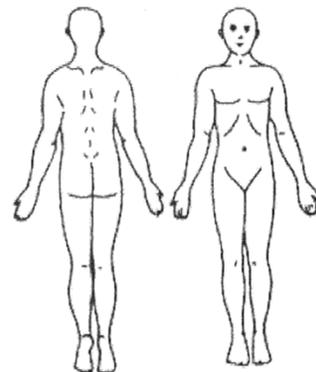
A = ache

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 paroxysmal 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	paresthasias	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)

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

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

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D&C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> 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 uncomplicated pregnancies |
| ____ number of c-sections | ____ number of vaginal deliveries |
| ____ number of miscarriages | ____ number of terminated pregnancies |

Menstrual history:

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

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

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

Non-drug Allergies (check all that apply.)

- | | | | |
|--|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> animals | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> dairy | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> eggs | | | |

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

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

Insurance Information

Who is responsible for your bill?

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Myself | <input type="checkbox"/> Auto insurance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Medicare | |
| <input type="checkbox"/> Worker's Comp. | <input type="checkbox"/> Medicaid | |

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 _____