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**(1) CONFIDENTIAL HISTORY All information is Confidential.**

Date

**Patient’s Name**

Address

City State Zip

Birthdate Age Race Ethnicity

SS# Marital Status S M D W Number of Children

Home Number Cell Number

Email Address

Preferred method of contact? Home phone Cell Phone Work Phone Email

**Employer** Occupation

Address

City State Zip

Phone May we contact your at work? Yes No

**Name of Spouse** Birthdate

Employer

Phone Occupation

**Emergency Contact**  Phone

Address City State Zip

Whom may we thank for referring you?

## Location Sign Website Other

Insurance Carrier

Is today’s visit due to an Auto Accident or a Work Injury

**Please allow us to copy your Drivers License and Insurance Card.**

**(2) SUBJECTIVE HISTORY** Patient’s Name

**#1 (Primary Reason for today’s appt)**

When did you first notice your current symptoms?

**Rate** your symptoms on a scale of 1-10

How often do you feel it? Constant Intermittent

Is this an ongoing or recurring problem? New Ongoing Recurring

Explain

What **AGGRAVATES** this condition?

What are you **UNABLE TO DO** because of this condition?

What have you done to RELIEVE these symptoms?

**#2(Secondary Reason for today’s appt)**

When did you first notice your current symptoms?

**Rate** your symptoms on a scale of 1-10

How often do you feel it? Constant Intermittent

Is this an ongoing or recurring problem? New Ongoing Recurring

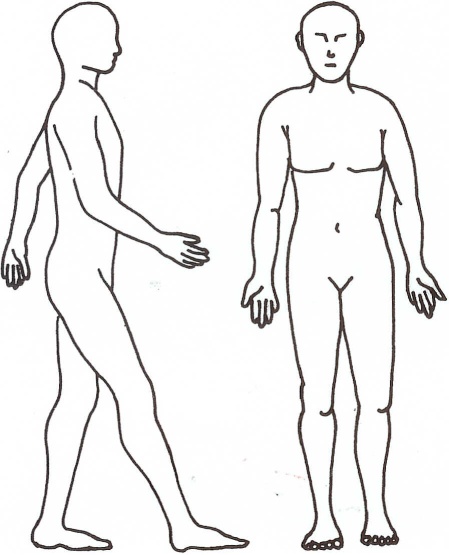
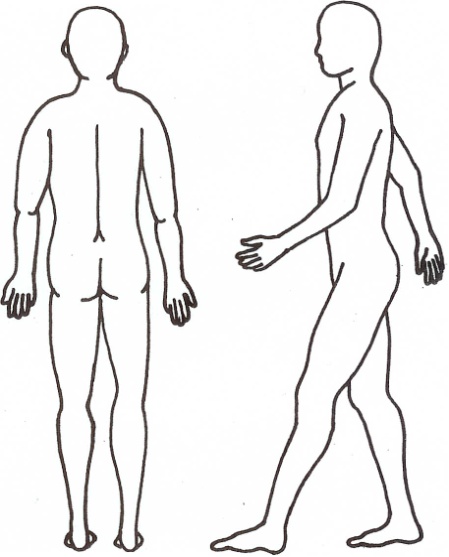
Explain

What **AGGRAVATES** this condition?

What are you **UNABLE TO DO** because of this condition?

What have you done to RELIEVE these symptoms?

COLOR ANY PAIN IN RED COLOR ANY NUMBNESS OR TINGLING IN BLUE

CIRCLE all that apply to your current symptoms. Quality of symptoms (What does it feel like?)

Sharp Shooting Stabbing Aching Dull

Stiffness Tightness Tingling Numbness

(3) Patient’s Name

TREATMENT BY OTHER DOCTORS FOR YOUR CURRENT SYMPTOMS/PROBLEMS

TESTS AND/OR PROCEDURES DATE OF TEST NAME OF DOCTOR

**ACTIVITIES OF DAILY LIVING**

How do your symptoms interfere with your ability to function? **Circle or check whichever applies:**

Getting out of a chair Mild Moderate Severe

Getting in/out of car Mild Moderate Severe

Going up/down stairs Mild Moderate Severe

Standing Mild Moderate Severe

Walking Mild Moderate Severe

Bending over Mild Moderate Severe

Exercising Mild Moderate Severe

Household chores Mild Moderate Severe

Lifting objects Mild Moderate Severe

Reaching overhead Mild Moderate Severe

Showering or bathing Mild Moderate Severe

Dressing myself Mild Moderate Severe

Lying down Mild Moderate Severe

Getting to sleep Mild Moderate Severe

Staying asleep Mild Moderate Severe

**CURRENT MEDICATIONS**

Please list all medications you are taking. Include prescribed drugs and over-the-counter drugs, vitamins etc.

Drug Name/Strength Frequency Name of Doctor prescribed

mg

mg

mg

mg mg

**ALLERGIES**

List anything that you are allergic to (medications, food, bee stings, etc) and how each affects you

Allergy Reaction

(4) Patient’s Name

**PAST MEDICAL HISTORY** (Please check all that apply)

AIDS or HIV Diverticulitis Leg/Foot Ulcers

Alcoholism Double Vision Liver Disease

Arthritis Fibromyalgia Loss Bladder/Bowel Control

Blood Clots Gout Lost Consciousness

Blood in Urine/Stools Heart Attack Lost/Gained Weight

Cancer Heart Murmur Osteoporosis

Coronary Artery Disease Hiatal Hernia Polio

Coughing up Blood High Blood Pressure Pulmonary Embolism

Cramping Legs/Arms High Cholesterol Reflux or Ulcers

Diabetes-Insulin Irritable Bowel Sleeping Disorder

Diabetes-Non-Insulin Kidney Disease Stroke

Thyroid Hyper/Hypo

**PAST SURGICAL HISTORY**

SURGERY/Year performed REASON FOR THE SURGERY

**SOCIAL HISTORY**

**ALCOHOL USE TOBACCO USE DRUG USE**

None Never Smoker Do you currently use street drugs?

Casual drinker Current every day smoker Yes No

Moderate drinker Current some day smoker If yes, please list

Heavy drinker Former Smoker

**FAMILY HISTORY**

Relative Age (if living) Illnesses Cause of death

Mother

Father

Sister 1

Sister2

Brother 1

Brother 2

(5) Patient’s Name

**WOMEN**

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period Initials

Comments

OTHER HEALTH FACTS Please add other information about your health that you would like the Doctor to know here:

ACKNOWLEDGEMENTS Please read each statement and initial your agreement.

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, Initials letters, emails or health information to me as an extension of my care in this office.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open Initials adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private confidential setting.

To the best of my ability, the information I have supplied is complete and truthful.

Initials

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself-not between my insurance company and this office. I accept responsibility for payment for all services rendered regardless of what my insurance carrier pays.

Any balance unpaid after thirty (30) days from the last date of service, will be subject to a $5 billing fee or finance charges of 1-1/2% per month. Furthermore, I will be responsible for all costs of collection including reasonable attorney fees.

Signature Date