



(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 _____

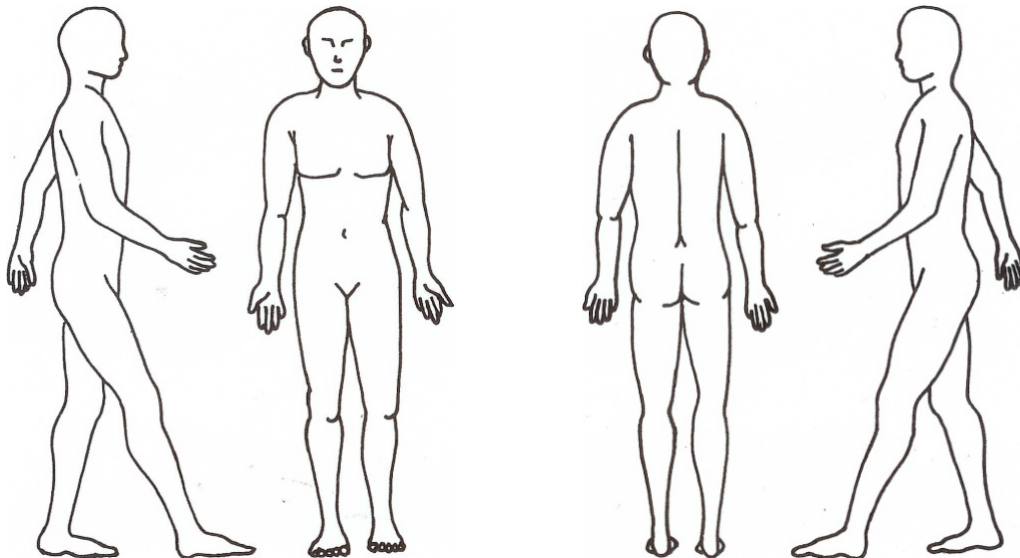
What **AGGRAVATES** this condition? _____

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)

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Loss Bladder/Bowel Control |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Gout | <input type="checkbox"/> Lost Consciousness |
| <input type="checkbox"/> Blood in Urine/Stools | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lost/Gained Weight |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Cramping Legs/Arms | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes-Insulin | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> Diabetes-Non-Insulin | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| | | <input type="checkbox"/> Thyroid Hyper/Hypo |

PAST SURGICAL HISTORY

SURGERY/Year performed

REASON FOR THE SURGERY

_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

ALCOHOL USE

- None
- Casual drinker
- Moderate drinker
- Heavy drinker

TOBACCO USE

- Never Smoker
- Current every day smoker
- Current some day smoker
- Former Smoker

DRUG USE

Do you currently use street drugs?

Yes No

If yes, please list

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