Miskelly Chiropractic Center, P.C.

(1) CONFIDENTIAL HISTORY **All Information is Confidential**

Date_____ **PLEASE USE INK TO FILL OUT**

Patient's Name_____

Address_____

City_____ State_____ Zip_____

Birthdate_____ Age_____ Race _____ Ethnicity XXXX

Marital Status S M D W Number of Children _____

Home Number _____ Cell Number _____

Cell Phone Provider _____

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 _____

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

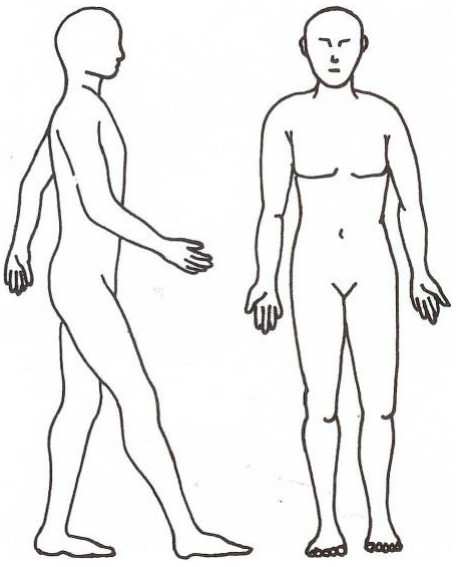
Explain_____

What **AGGRAVATES** this condition?_____

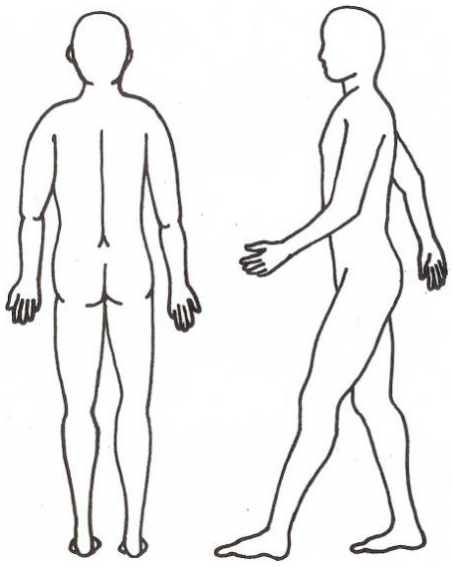
What are you **UNABLE TO DO** because of this condition?_____

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	

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

Patient's Name_____

PAST MEDICAL HISTORY (Please check all that apply)

_____ AIDS or HIV
_____ Alcoholism
_____ Arthritis
_____ Blood Clots
_____ Blood in Urine/Stools
_____ Cancer
_____ Coronary Artery Disease
_____ Coughing up Blood
_____ Cramping Legs/Arms
_____ Diabetes-Insulin
_____ Diabetes-Non-Insulin
_____ Difficulty Breathing-Asthma
_____ Diverticulitis
_____ Double Vision
_____ Fibromyalgia
_____ Gout
_____ Heart Attack
_____ Heart Murmur
_____ Hiatal Hernia
_____ High Blood Pressure
_____ High Cholesterol
_____ Irritable Bowel
_____ Kidney Disease
_____ Leg/Foot Ulcers
_____ Liver Disease
_____ Loss Bladder/Bowel Control
_____ Lost Consciousness
_____ Lost/Gained Weight
_____ Osteoporosis
_____ Polio
_____ Pulmonary Embolism
_____ Reflux or Ulcers
_____ Sleeping Disorder
_____ Stroke
_____ 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.

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

X_____ It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open 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.
Initials

X_____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.

X _____ _____

Signature Date