

Patient History

Name: _____ Address _____ Apt _____

City: _____ State: _____ Zip Code _____

Home Phone: _____ Birth Date _____ Age _____ Sex M F

E-mail Address _____ Cell phone: _____

Social Security#: _____ Drivers License # _____

Insurance #: _____ Circle one: Single Married Partner Divorced Widowed Separated

Employer: _____ Type of Work: _____

Work Phone: _____ Spouses Social # _____

Spouse Name: _____ Spouses Insurance # _____

Spouse Employer _____ Business Phone _____

Type of Work _____ Name & Ages of Children _____

Name & Number of Emergency Contact _____

Referred to this office by: _____

Who is responsible for your bill? You and Spouse Worker's Comp Auto Insurance Medicare

Current Health Condition

Your health Concern: _____

Other Doctors seen for this yes No Who? _____

Type of Treatment _____ Results _____

When did this begin? _____ Has it occurred before yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other _____

Date of Accident _____ Time Of Accident _____ Reported to employer Y N

What drugs to you take (please list)? Nerve pills/antidepressants pain Killers/Muscle relaxers

Blood Pressure Medication Insulin Other _____

Do you have any other condition other than that which you are consulting us? _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones Other _____

Major Falls or Accidents: _____

Hospitalization (Other than above): _____

Previous Chiropractic Care: N Y Doctor's Name & Last visit date _____

Exercise: Regularly Occasionally Rarely Never Exercise Type: _____

NAME: _____

Below are a list of diseases which may seem unrelated to the purpose of your Appointment. However, these questions must be answered carefully as these problems can affect the overall course of your care.

Check any of the Following Diseases you have had ever:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Hepatitis A B C D E ____ | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE How Much? |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee ____ cups/day |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Tea ____ cups/day |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes Type I or Type II | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Soda ____ cups/day |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Cigarettes ____ packs/day |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid hypo or hyper | <input type="checkbox"/> Eczema | <input type="checkbox"/> White Sugar |

Have you tested positive for HIV? yes No

Which is your dominant hand? Right or Left
(Circle one) Ambidextrous

Check Any of the Following You had the Past 6 Months:

Musculo-Skeletal

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Jaw Clicks
- General Stiffness

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL

- Fatigue
- Allergies _____
- Loss of Sleep (use back of page if needed)
- Fever
- Headaches

DIGESTIVE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall Bladder Trouble
- _____

- Gas/Bloating
- Heartburn
- Black/Bloody Stool
- IBS

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Cardio- Pulmonary**
- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heart Beat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems/Glasses
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose/Sinus Problems

Male/Female

- Menstrual Irregular
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Problems
- Impotent

Psychological Diagnosis

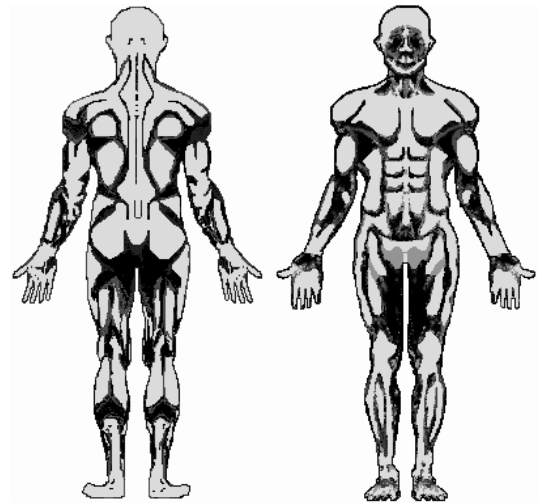
- _____
- _____
- _____

FEMALES ONLY

When was you last Period? _____

Are you Pregnant?

- Yes NO Not Sure



Please outline on the diagram the area of discomfort.

Family History

The following family have a same or similar as I do:

- Mother
- Father
- Brother
- Sister
- Sister
- Spouse
- Child

