Confidential Patient Record **DATE:_____**

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 do 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:

- ☐ Hepatitis A B C D E ___
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes Type I or Type II
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid hypo or hyper
- ☐Influenza
- ☐Pleurisy
- ☐ Arthritis _____
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE	How Much?
☐ Coffee	__cups/day
☐ Tea	__cups/day
☐ Soda	__cups/day
☐ Alcohol	_____
☐ Cigarettes	___ packs/day
☐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

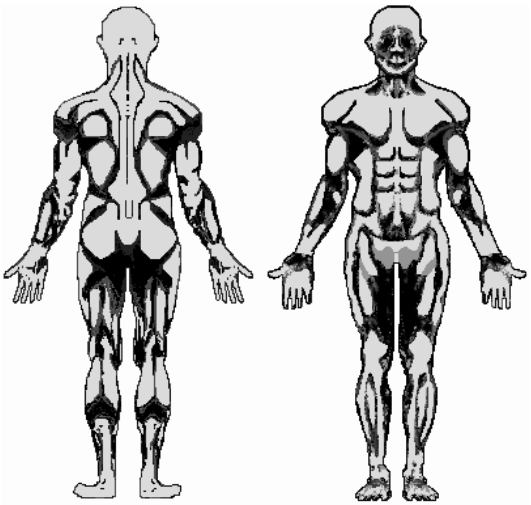
Psychological Diagnosis

- ☐ _____
- ☐ _____
- ☐ _____

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
- ☐ Spouse
- ☐ Child
- ☐ Other _____

NAME:_____

If this is an accident Related Injury, Please ask receptionist for the accident forms. Thank You.

Please include any other relevant data you would like to communicate to the Doctor:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I Understand and agree that health and accident insurance policies are an arrangement between an insurance Carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

***I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays is for examination only and the x-ray negatives 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*.** **No returns on any equipment or vitamin/supplements.**

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

_____

Don't Write Below This Line

Diagnosis:

Analysis: _____

Patient Accepted □ Yes □ No Doctor's Signature