Patient Information

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____ Date of Birth:_____

Employer's Name and Address:_____

_____

Email:_____ How did you hear about us?:_____

If referred, who referred you to our office?:_____

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1)_____
2)_____
3)_____
4)_____
5)_____

List approximately how long you have noticed these problems:

1)_____
2)_____
3)_____
4)_____
5)_____

Is there a certain time of day any of these problems are better or worse?

_____
_____
_____

List the treatments you have used for these problems:

□Ice □Heat □Exercise □Massage □Chiropractic □Rest
□Medication(s):_____
_____
□Other:_____

Describe any sudden movements, injuries, falls, accidents, etc. that have caused your problem(s): _____
_____

Have you had similar health problems or injuries before? □Yes □No _____
_____

Names of all doctors you have seen for these problems and treatment you received: _____
_____
_____

Have your health problems: □ Improved □ Worsened □ Stayed the Same
List anything that makes your conditions worse: _____
_____
_____

Please check off and describe how this problem interferes with your work and/or personal life:

□ Work Activities Effected: _____
Have you missed any days of work? □Yes □No If yes, dates missed:_____
□ Home Activities Effected: _____
□ Recreational Activities Effected: _____

Previous Health History

Who is your primary care physician/family doctor?: _____
When were you last seen there:_____
May we send them updates on your treatment/condition: □**Yes** □**No**

During the last year, has a doctor treated you for any health problem? □**Yes** □**No**
If yes, please explain: _____
_____
_____

Have you ever received Chiropractic care? □**Yes** □**No** □**If yes, please list the doctor's name and for what problems:** _____-
_____
_____

Please check the prescription drugs you are currently taking: □Anti-depressants □Anti-Inflammatory
□Birth Control Pills □Blood Pressure Medication □Diet Pills □Blood Sugar Medication
□Muscle Relaxers □Insulin □Pain Pills □Sleeping Pills
Other (please list):_____
_____

Please check the over the counter drugs you are using and how much your take:
□Aspirin:_____ □Tylenol:_____ □Motrin:_____ □Alleve:_____
□Advil:_____ □Other:_____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____
_____
_____

List any vitamins or nutritional supplements you are currently taking or have taken recently: _____
_____
_____

Check any of the following you are interested in learning more about or would like information on:
□Massage Therapy □Acupuncture □Nutrition Testing □Live Blood Cell Analysis □Spinal Decompression
□Physician Supervised Weight Loss □Wellness Coaching □Health Workshops and Seminars

Financial Responsibility

Who is responsible for your bill? □Insurance □My Employer □Spouse □I am □Other
Type of Insurance: □Automobile □Health □Worker's Comp
Insurance Company's Name, Address and Phone #: _____
_____

Your fees are due and payable at the time examination, X-rays and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature:_____ Social Security No.:_____ Date:

Parent or Guardian Signature (if patient is minor)

_____ Social Security No.:_____ Date:

Family Health History

Marital Status: □ Married □ Single □ Widowed □ Separated □ Divorced
Name of spouse:_____
Spouse Phone Number: _____
Name and ages of children: _____
_____

To help your doctor determine if your health problem is hereditary please fill out the following table on the health of your immediate family members.

	Age (if living)	**Age at death (if deceased)**	**Chronic Health Problems**
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily:_____
Do you drink? □ Yes □ No If yes, how many drinks/week:_____
Do you exercise regularly? Yes No If yes, describe what type and how often:_____
_____
Do you consider yourself to have a good social support system (friends/family)? Yes No
Describe a typical daily diet (only include meals/snacks you regularly eat):
Breakfast:_____ Snack (time eaten): _____
Lunch: _____ Snack (time eaten): _____
Dinner: _____ Snack (time eaten): _____

Review of Systems

Check any symptoms you've had in the past year:

□ Muscle Pain	□ Fever	□ Chills	□ Fatigue	□ Eye pain	□ Blurred vision
□ Double vision	□ Headaches	□ Joint swelling	□ Nosebleed	□ Ringing in ears	□ Chest pain
□ Skin changes	□ Fainting	□ Wheezing	□ Chest tightness	□ Anxiety	□ Heartburn
□ Nausea	□ Vomiting	□ Constipation	□ Diarrhea	□ Bloody stool	□ Joint stiffness
□ Difficult/ painful urination	□ Unexpected weight loss or gain	□ Difficulty swallowing	□ Heart Palpitations	□ Poor wound healing	□ Shortness of breath
□ Depression	□ Tremors	□ Seizures	□ Easy bleeding/ bruising	□ Excessive thirst or urination	□ Allergic Reactions