**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT INFORMATION FORM**

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|  | | | | | | | | | | | | | | | | Today’s Date: | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | Male  ☐Female | | | | | | | | | | | | | Age: | | | | | | | | | | | | Married  ☐Divorced | | | | | | | | | | | | Single  ☐Separated | | | | | | | | | | | | Widowed  ☐\_\_\_\_\_\_\_\_ | | | |
| Address: | | | | | | | | | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | | | | | | | | | | | | | Zip: | | | |
| Home Phone: | | | | | | | | | | Cell: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Fax: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social Security #: | | | | | | | | | | Driver’s License: | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Spouse’s Name: | | | | | | | | | | Ages of Children: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Occupation/Job Title: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer/Business Name: | | | | | | | | | | Business Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Business Phone: | | | | | | | | | | Type of Work: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How Did You Hear About Us? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| emergency Contact: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone #: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Insurance** | Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Who Is Responsible For Your Bill? | | | Self  Worker’s Comp | | | | | | | | | | | Auto Insurance  Medicare | | | | | | | | | | | | | | Medicaid  Other (Be Specific): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Personal Health Insurance Carrier: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Health ID Card #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insured Person’s Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Primary Care Physician: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insured Person’s Social Security #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Pharmacy: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Health Condition** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please Circle Areas of Discomfort** | | | | | | | | | | | | | | | | | | | | | | | | **Chief Complaint: (Why Are You HERE Today?)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Body Area Involved: | | | Cervical (Neck)  Spine (Mid-Back), Ribs, Pelvis (Low Back) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Upper Extremity (Arms, Wrist, Hands)  Lower Extremity (Legs, Feet, Toes) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Condition: | | | New  Recurring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Exacerbation  Chronic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mechanism of Onset: | | | Auto  Work | | | | Fall  Lifting | | | | | | | | | | | Over Exertion  Repetitive Motion | | | | | | | | | | | | | | | | | Unknown  Slept Wrong | | | | | | | | | | | | | | Slip or Fall  No Injury | | | | | | | | | | | | | Other | | | | | | |
| Symptoms: | | | Pain  Numbness | | | | Stiffness  Weakness | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | |
| Location: | | | Left  Right | | | | Bilateral | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | |
| Quality: | | | Burning  Diffuse | | | | Dull/Aching  Localized | | | | | | | | | | | Sharp  Shooting | | | | | | | | | | | | | | | | | Stabbing  Throbbing | | | | | | | | | | | | | | Tightness  Tingling | | | | | | | | | | | | | Radiating  Other | | | | | | |
| On A Scale of 0-10, (10 Being the Worst) Rate Your Symptoms (Resting): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | | | | 1 | | | 2 | | | | | | 3 | | 4 | | | 5 | | | | | | 6 | | | | 7 | | | | 8 | | | 9 | 10 |
| On A Scale of 0-10, (10 Being the Worst) Rate Your Symptoms (With Activity): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | | | | 1 | | | 2 | | | | | | 3 | | 4 | | | 5 | | | | | | 6 | | | | 7 | | | | 8 | | | 9 | 10 |
| Duration: Symptom(s) Started: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Symptom(s) Worsened: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Symptom(s) Last Occurred: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Symptom(s) Last Episode: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injury Occurred: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accident Occurred: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Timing Worse In The: | | Morning | | | | | | | | | | Afternoon | | | | | | | | | | | | | Night | | | | | | | | | | | | W/Activity | | | | | | | | | | | | | | Constant | | | | | | | | | | | | | Intermittent | | | | |
| Associated Signs  & Symptoms: | | Blurred  Vision  Depression  Dizziness | | | | | | | | | | | | | | | Headaches  Irritability/Mood Swing  Localized Tingling | | | | | | | | | | | | | | | | | | | | Nausea  Radiating  Ringing In Ears | | | | | | | | | | | | | | | | | | | | | Sleep  Disturbance  Stiffness | | | | | | | | | | |
| Quality Of Headaches: | | Dull  Sharp | | | | | | | Throbbing  Stabbing | | | | | | | | | | | Aura  No Aura | | | | | | | | | | | Radiation:  Weakness: | | | | | | | | | | | | Left  Left | | | | | | | | | | | Right  Right | | | | | | | | | | | | Bilateral  Bilateral | | |
| Other Assoc. Signs  & Symptoms: | | Aches  Cold Limb  Dizziness  Fatigue | | | | | | | | | Fever  Heartburn  Muscle Spasm  Nausea | | | | | | | | | | | | | | | Numbness  Pale Bluish Skin  Panic  Pins & Needles | | | | | | | | | | | | | | | | | | Runny Nose  Stiffness  Sweating  Swelling | | | | | | | | | | | | | | | Tingling  Vomiting  Weakness | | | | | | | | | |
| Modifying Factors –  Symptoms Better With: | | Activity  Bending | | | | Cold  Heat | | | | | | | | Massage  Movement | | | | | | | | | OTC Meds  RX Meds | | | | | | | | | | Rest  ☐Stretching | | | | | | | | | | | | | Sitting  ☐Standing | | | | | | | | | Twisting  ☐Walking | | | | | | | | | | Nothing  Helps | | | |
| Since Condition Began, Has Anything Permanently Helped You? | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has Anything That You Have Done, Thus Far, Fixed Your Problem | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Employment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | | | | | | | | Work (Hrs/Day): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Job Classification: | | | Sitting | | Light | | | | | | | | Moderate | | | | | | | | | Heavy Lifting | | | | | Lifting Frequency: | | | | | | | | | | | Constant  (66-100% Day) | | | | | | | | | | | | Frequent  (33-65% Day) | | | | | | | | | | | | | Occasional  (0-32% Day) | | | | | |
| Work Activity Postures: (Hrs/Day) | | | | | | | | Sitting  Standing | | | | | | | | | | | | | Walking  Climbing | | | | | | | | | | | | | Pushing  Pulling | | | | | | | | | | | | | | Kneeling  Reaching | | | | | | | | | | | | | Twisting  Bending | | | | | | | |
| Repetitive Activities: (Hrs/Day) | | | | | | | | Computer  Phone | | | | | | | | | | | | | | | | | | | | Machinery  Hand Tools | | | | | | | | | | | | | | | | | | | | | | | | Assembly  Grasping | | | | | | | | | | | | | | | | |
| How Does This Condition Effect Job Performance: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Mild Painful (Can Do)  Moderate Painful (Limited) | | | | | | | | | | | | | | | | | | | | | Severe (Unable To Perform)  Other (Explain) | | | | | | | | | | | |

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| Daily Activities: On A Scale Of 0-10, To What Level Are You Experiencing Symptoms  While Performing These Activities | | | | | | | | | | | |
| Activity  (Check applicable column) | **0**  **No Effect** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10**  **Unable to do** |
| Bending: |  |  |  |  |  |  |  |  |  |  |  |
| Care –Infirm Family: |  |  |  |  |  |  |  |  |  |  |  |
| Carrying Groceries: |  |  |  |  |  |  |  |  |  |  |  |
| Change Pos.–Sit-Stand: |  |  |  |  |  |  |  |  |  |  |  |
| Climb Stairs: |  |  |  |  |  |  |  |  |  |  |  |
| Driving: |  |  |  |  |  |  |  |  |  |  |  |
| Extended Computer Use: |  |  |  |  |  |  |  |  |  |  |  |
| Feeding: |  |  |  |  |  |  |  |  |  |  |  |
| Household Chores: |  |  |  |  |  |  |  |  |  |  |  |
| Kneeling: |  |  |  |  |  |  |  |  |  |  |  |
| Lift Children: |  |  |  |  |  |  |  |  |  |  |  |
| Lifting: |  |  |  |  |  |  |  |  |  |  |  |
| Pet Care: |  |  |  |  |  |  |  |  |  |  |  |
| Reading (Concentration): |  |  |  |  |  |  |  |  |  |  |  |
| Self Care: |  |  |  |  |  |  |  |  |  |  |  |
| Self Care–Bathing: |  |  |  |  |  |  |  |  |  |  |  |
| Self Care–Dressing: |  |  |  |  |  |  |  |  |  |  |  |
| Self Care–Shaving: |  |  |  |  |  |  |  |  |  |  |  |
| Sexual Activities: |  |  |  |  |  |  |  |  |  |  |  |
| Sleep: |  |  |  |  |  |  |  |  |  |  |  |
| Static Sitting: |  |  |  |  |  |  |  |  |  |  |  |
| Static Standing: |  |  |  |  |  |  |  |  |  |  |  |
| Walking: |  |  |  |  |  |  |  |  |  |  |  |
| Yard Work: |  |  |  |  |  |  |  |  |  |  |  |

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| **Below is a list of diseases that may seem unrelated to the purpose of your appointment.**  **However, these questions must be answered carefully as the problems can affect your overall course of care.**  **REVIEW OF SYMPTOMS – Please fill out all of the sections, even if “DENY”** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Constitutional:  I Deny Any Const. Issue(s) | | | Chills  Night Sweats | | | | | | | | | | | | | | Weight Gain  Weight Loss | | | | | | | | | | | | | | | | | | | | ☐Fatigue  ☐Fever | | | | | | | | | | | | | | | ☐Daytime Somnolence (Drowsiness) | | | | | | | | | | |
| Eye/Vision: I Deny Any Eye/Vision Issue(s) | Blindness  Double Vision | | | Eye Pain  Photophobia | | | | | | | | | | | | | | Tearing  Blurred Vision | | | | | | | | | | | | | Field Cuts  (Visual Field Defect) | | | | | | | | | Cataracts  Glaucoma | | | | | | | | Change In Vision  Itching (Around Eyes) | | | | | | | | Wear Glasses And/Or  Contact Lenses | | | | | | |
| Ears, Nose, & Throat:  I Deny Any E/N/T Issue(s) | Bleeding  Discharge  Dizziness  Snoring | | | | Fainting  Headaches  Loss of Smell  Sore Throats (Frequent) | | | | | | | | | | | | | | | Nasal Congestion  Sinus Infections  Dental Implants | | | | | | | | | | | | | | | Ear Drainage  Ear Infection(s)  Hearing Loss  Tinnitus (Right in Ears) | | | | | | | | | | Post Nasal Drip  Difficulty Swallowing  Ear Pain | | | | | | | | | Hoarseness  Rhinorrhea (Runny Nose)  Sinus Infections  TMJ Problems | | | | | | | | |
| Respiration:  I Deny Any Respiratory Issue(s) | Asthma | | | | Coughing Up Blood | | | | | | | | | | | | | | | Sputum Production | | | | | | | | | | | | | | | Cough | | | | | | | | | | Shortness of Breath | | | | | | | | | Wheezing | | | | | | | | |
| Cardiovascular:  I Deny Any CARDIO. Issue(s) | Angina (Chest Pain or Discomfort)  Chest Pain  Claudication (Leg Pain or Achiness) | | | | | | | | | | | Heart Murmur  Heart Problems  Orthopnea (Difficulty Breathing While Lying Down) | | | | | | | | | | | | | | | | | | | | | | | | Palpitations (Irregular Or Forceful Breathing of the Heart)  Paroxysmal Nocturnal Dyspnea (Waking At Night With Shortness of Breath) | | | | | | | | | | | | | | | Swelling of Legs  Ulcers  Varicose Veins | | | | | | | | | | | |
| Gastrointestinal:  I Deny Any GI Issue(s) | Abdominal Pain  Belching  Black, Tarry Stools  Constipation | | | | | | | | | | | | Diarrhea  Difficulty Swallowing  Heartburn  Hemorrhoids | | | | | | | | | | | | Indigestion  Jaundice  (Yellowing of Skin)  Nausea  Rectal Bleeding | | | | | | | | | | | | | | | | Abnormal Stool Caliber (Quality)  Abnormal Stool Color  Abnormal Stool Consistency | | | | | | | | | | | | | | | | | | | Vomiting Blood  ☐VOMITING | | |
| Female: I Deny Any Female Issue(s) | Birth Control Therapy  Breast Lump/Pain  Burning Urination | | | | | | | | | | | | Cramps  Frequent Urination  Hormone Therapy | | | | | | | | | | | | | | | | | | | | | | | Irregular Menstruation  Urine Retention  Vaginal Bleeding | | | | | | | | | | | | | | | Vaginal Discharge | | | | | | | | | | | |
| Male: I Deny Any Male Issue(s) | Burning Urination  Prostate Problems | | | | | | | | | | | | Erectile Dysfunction | | | | | | | | | | | | | | | | | | | | | | | Frequent Urination  Urination Retention | | | | | | | | | | | | | | | Hesitancy/Dribbling | | | | | | | | | | | |
| Endocrine: I Deny Any Endocrine Issue(s) | Cold Intolerance  Diabetes | | | | | | Excessive Appetite  Excessive Hunger | | | | | | | | | | | | | | | Excessive Thirst  Frequent Urination | | | | | | | | | | | | | | | Goiter  Hair Loss | | | | | | | | | | | | Heat Intolerance  Unusual Hair Growth | | | | | | | | | | | | | Voice Changes |
| Skin: ☐I Deny Any Skin Issue(s) | Changes in Nail Texture  Changes in Skin Color | | | | | | | | | | | | | | | Hair Growth  Hair Loss | | | | | | | | | | Hives  Itching | | | | | | | Paresthesia (Numbness, Prickling, or Tingling) | | | | | | | | | | | | | Rash  History of Skin Disorders | | | | | | | | | | | | Skin Lesions /Ulcers  Varicosities | | | | |
| Nervous Systems:  I Deny Any NS Issue(s) | Dizziness  Facial Weakness | | | | | Headaches  Limb Weakness | | | | | | | | | | | | | Loss of Consciousness  Loss of Memory | | | | | | | | | | | | | | | Numbness  Seizures | | | | | | | | | Sleep Disturbance  Stress | | | | | | Strokes  Tremors | | | | | | | | Unsteadiness of Gait | | | | | |
| Psychological:  I Deny Any Psychological Issue(s) | Anhedonia (Inability to Experience Joy or Enjoy Life) | | | | | | | Anxiety  Appetite Changes | | | | | | | | | | | | | | | Behavioral Change(s)  Bipolar Disorder | | | | | | | | | | | | | Confusion  Convulsions | | | | | | | | | | | | | Depression  Insomnia | | | | | | | | | | | | Memory Loss  Mood Changes | |
| Allergy: I Deny Any Allergy Issue(s) | Anaphylaxis (History of Sneezing) | | | | | | | | | | | | | | Food Intolerance | | | | | | | | | | | | | | | | | | | | | | Itching  Nasal Congestion | | | | | | | | | | | | | Sneezing | | | | | | | | | | | | |
| Hematology: I Deny Any Hematology Issue(s) | Anemia  Bleeding | | | | | | | | | | | | | Blood Clotting  Blood Transfusion(s) | | | | | | | | | | | | | | | | | | | | | | Bruises Easily  Fatigue | | | | | | | | | | | | | | | Lymph Node Swelling | | | | | | | | | | | |
| **Past Health History – Please fill out carefully as these problems can affect your overall course of care.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Childhood Illness:  I Deny Any Childhood Illness(es) | | Add  Allergies/HayFever  Asthma  Atopic Dermatitis (Eczema) | | | | | | | | | | | | Bed Wetting  Cerebral Palsy  Chicken Pox  Depression | | | | | | | | | | | | | Diabetes  Ear Infections  Fetal Drug  Exposure | | | | | | | | | | | | Food Allergies  Headaches  Hepatitis  HIV | | | | | | | Measles  Mumps  Rash  Scoliosis | | | | | | | Seizure Disorder  Sickle cell Anemia  Spina Bifida  Other (Please Describe) | | | | | | | | | |
| Adult Illness:I Deny Any Adult Illness(es) | | Alzheimers  Anemia  Arthritis  Asthma  Cancer  Chicken Box  Chron’s/Colitis  CRPS (RSD) | | | | | | | CVA (Stroke)  Cystic Kidney Disease  Depression  Diabetes (Insulin)  Diabetes (Non Insulin)  Ear Infections (Frequent)  Emphysema  Eye Problems | | | | | | | | | | | | | | | | | | | | Fibromyalgia  Heart Disease  Hepatitis  HIV  Hypertension  Influenza Pneumonia  Liver Disease  Lung Disease | | | | | | | | | | | | | Lupus Erythema (Discoid)  Lupus Erythema (Systemic)  Multiple Sclerosis  Parkinson’s Disease  Pleurisy  Pneumonia  Psychiatric Problems  Scoliosis | | | | | | | | | | | Seizure Disorder  Shingles  STD’s (Unspecified)  Suicide Attempt(s)  Thyroid Problems  Vertigo  Past History of Similar Symptoms To Your Current Condition | | | | | | | | | |
|  | | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surgeries:☐I Deny Any Surgery (ies) | | Angioplasty  Appendectomy  Caesarean Section  Cardiac Catheterization  Carpal Tunnel Repair | | | | | | | | | | | | Coronary Artery Bypass  Cosmetic  D & C  Dental Surgery  ☐Gall Bladder | | | | | | | | | | | | | | | | Hemorrhoidectomy  Hernia Repair  Hysterectomy  Joint Reconstruction  ☐Joint Replacement | | | | | | | | | | | | | | Laminectomy  Mastectomy  Pacemaker Insertion  Rotator Cuff  Spinal Fusion | | | | | | | | | | | Tonsillectomy  Other | | | | | | | |
| OB/GYN:☐I Deny Any OB/GYN Issues | | I have never been pregnant  I have been pregnant in the past  I am currently pregnant | | | | | | | | | | | | | | | | | | | | | | **Menstrual History:**  Age of Onset \_\_\_\_\_ | | | | | | | | | | | | | | My Menses Is Regular  My Menses Is Irregular  I Am Currently In Menopause | | | | | | | | | | | | | | | | | Date of Last Menses  \_\_\_/\_\_\_/\_\_\_ | | | | | | | |
| Injuries:☐I Deny Any Injury (ies) | | Back Injury  Broken Bones  Severe Fall | | | | | | | | Fracture  Disability  Head Injury | | | | | | | | | | | | | | | Industrial Accident  Joint Injury  Severe Laceration | | | | | | | | | | | | | | | | | | | Motor Vehicle Accident  Mild/Moderate Soft Tissue Injury  Severe Soft Tissue Injury | | | | | | | | | | | | | | | | | | |
| Immunizations:  ☐I Deny Any Immunization(s) | | DTaP (Diptheria, Tetanus & Pertussis) | | | | | | | Flu  Hepatitis A  Hepatitis B | | | | | | | | | | | | Hepatitis C  Influenza  IPV (Polio) | | | | | | | | | | | MMR (Measles, Mumps, & Rubella)  Pneumococcal  PPD (Mantoux Test-TB) | | | | | | | | | | | | | | Small Pox  TB  Varivax (Chicken Pox) | | | | | | | | | | | | | Whopping Cough (Pertussis) | | | |
| Non-Drug Allergies:  ☐I Deny Any Non-Drug Allergies | | Animals | | | | | | | | | Dairy | | | | | | | | | | | | | | | | | Eggs | | | | | | | | | | Food Coloring | | | | | | | | | Mold | | | | | | | | | | | | Pollen | | | |

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| **Previous Treatment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous Chiropractic Care? | | | | | Yes If Yes, Who? (Name)  No | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have You Seen Other Doctors for this Condition? | | | | | Yes If Yes, Who? (Name)  No | | | | | | | Location of Office: | | | | | | | | | Type of Treatment: | | | | | | | | | |
| Were You Sastified with the results of your treatment? | | | | | Yes Explain:  No | | | | | | | | | | | | | | | | | | | | | | | | | |
| aRE YOU cURRENTLY tAKING anY pRESCRIPTION mEDICATIONS? | | | | | Yes iF yES, pLEASE mARK OR lIST (bE sPECIFIC)  No | | | | | | aLLERGY mEDICATION  antI-dEPRESSANTS | | | | | bLOOD pRESSURE mEDS.  iNSULIN | | | | ☐mUSCLE rELAXERS  ☐NERVE PILLS | | | | | | pAIN kILLERS  oTHER (PLEASE sPECIFY) | | | | |
| dO yOU wEAR aNY oF tHE fOLLOWING? | | | | | hEAL lIFTS  iNNER sOLES | | | | | | aRCH sUPPORTS  oRTHOTICS | | | | | pLEASE lIST aNY oTHER cONDITIONS yOU fEEL wE sHOULD kNOW aBOUT – eVEN IF uNRELATED | | | | | | | | | | | | | | |
| **fAMILY hISTORY – eNTER iNITIALS bELOW: a = aLIVE d = dECEASED** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_ gENERAl  fAMILY  \_\_\_ faTHER | | | \_\_\_ mOTHER  \_\_\_ pATERNAL gRANDFATHER | | | | | \_\_\_ pATERNAL gRANDMOTHER  \_\_\_ mATERNAL gRANDFATHER | | | | | | | \_\_\_ mATERNAL gRANDMOTHER  \_\_\_ sON(S) | | | | | | | | | \_\_\_ dAUGHTER(S)  \_\_\_ bROTHER(S) | | | | \_\_\_ sISTER(S) | | |
| **nAME** | | | | | | | | | **rELATION** | | | | | | | | | | **pAST & pRESENT hEALTH pROBLEMS** | | | | | | | | | | | |
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| **sOCIAL hISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **aLCOHOL:** | | nEVER  dAILY  wEEKLY  mONTHLY | | sOCIAL cONSUMPTION oNLY | | | ☐bEER  ☐lIQOUR  ☐WINE | | | oz.’S # gLASSES | | | **dIET:**  mARK ALL THAT aPPLY | | | | | hIGH fAT  hIGH fIBER  hIGH pROTEIN  hIGH sALT | | | | low cALORIE  lOW cARB  ☐ LOW SUGAR | | | | | low fIBER  lOW sALT | | | |
| **dRUGS:** | dENY aNY iLLEGAL dRUG uSE  dENY uSE OF iv dRUGS | | | | | hAVE nOT uSED dRUGS sINCE \_\_\_\_\_  hAVE uSED dRUgS fOR \_\_\_\_\_ | | | | | | | **tOBACCO:** | | | | dENY tOBACCO use  lIVE W/A sMOKER  qUIT sMOKING | | | | | | # pER:  \_\_\_ | | dAY  wEEK  ☐ MONTH | | | | | ☐ # CHEW  \_\_\_\_ |
| **pLEAE rEAD cAREFULLY aND sIGN bELOW** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that chiropractic clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to chiropractic clinic will be credited to my account upon receipt. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Guardian or Spouse’s Signature of Authorizing care:**  (Signature Indicates Consent To Treat) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | |
| **Patient (Print Name):** | | | | | | | | | | | | | | **Patient’s Signature:** | | | | | | | | | | | | | | | **Date:** | |