

PATIENT INFORMATION FORM

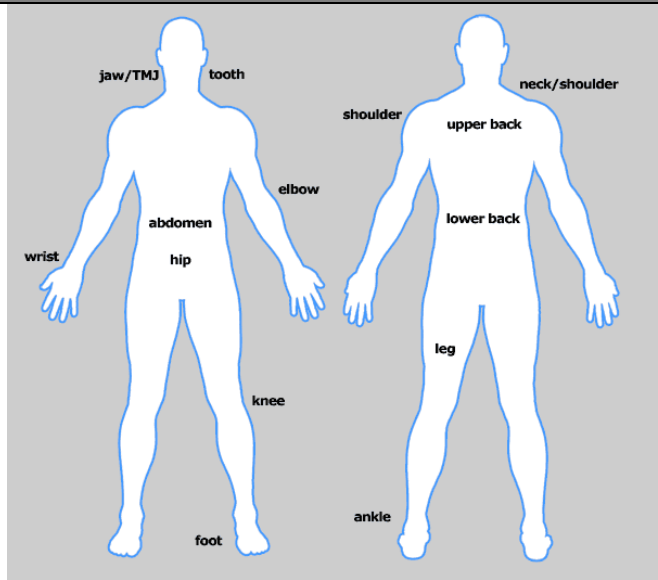
NAME:	TODAY'S DATE: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:	DATE OF BIRTH: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> _____
ADDRESS:	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 #:
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INSURANCE	ADDRESS:	RELATIONSHIP:
	WHO IS RESPONSIBLE FOR YOUR BILL? <input type="checkbox"/> SELF <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> 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?)

BODY AREA INVOLVED:	<input type="checkbox"/> CERVICAL (NECK)	<input type="checkbox"/> UPPER EXTREMITY (ARMS, WRIST, HANDS)
	<input type="checkbox"/> SPINE (MID-BACK), RIBS, PELVIS (LOW BACK)	<input type="checkbox"/> LOWER EXTREMITY (LEGS, FEET, TOES)
CONDITION:	<input type="checkbox"/> NEW	<input type="checkbox"/> EXACERBATION
	<input type="checkbox"/> RECURRING	<input type="checkbox"/> CHRONIC
MECHANISM OF ONSET:	<input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> OVER EXERTION <input type="checkbox"/> UNKNOWN <input type="checkbox"/> SLIP OR FALL <input type="checkbox"/> OTHER	
	<input type="checkbox"/> WORK <input type="checkbox"/> LIFTING <input type="checkbox"/> REPETITIVE MOTION <input type="checkbox"/> SLEPT WRONG <input type="checkbox"/> NO INJURY	
SYMPTOMS:	<input type="checkbox"/> PAIN <input type="checkbox"/> STIFFNESS	
	<input type="checkbox"/> NUMBNESS <input type="checkbox"/> WEAKNESS	
LOCATION:	<input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL	
	<input type="checkbox"/> RIGHT	
QUALITY:	<input type="checkbox"/> BURNING <input type="checkbox"/> DULL/ACHING <input type="checkbox"/> SHARP <input type="checkbox"/> STABBING <input type="checkbox"/> TIGHTNESS <input type="checkbox"/> RADIATING	
	<input type="checkbox"/> DIFFUSE <input type="checkbox"/> LOCALIZED <input type="checkbox"/> SHOOTING <input type="checkbox"/> THROBBING <input type="checkbox"/> TINGLING <input type="checkbox"/> 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) WORSENE:											
SYMPTOM(S) LAST OCCURRED:											
SYMPTOM(S) LAST EPISODE:											
INJURY OCCURRED:											
ACCIDENT OCCURRED:											
TIMING WORSE IN THE:	<input type="checkbox"/> MORNING	<input type="checkbox"/> AFTERNOON	<input type="checkbox"/> NIGHT	<input type="checkbox"/> W/ACTIVITY	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> INTERMITTENT					
ASSOCIATED SIGNS & SYMPTOMS:	<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> DEPRESSION <input type="checkbox"/> DIZZINESS	<input type="checkbox"/> HEADACHES <input type="checkbox"/> IRRITABILITY/MOOD SWING <input type="checkbox"/> LOCALIZED TINGLING	<input type="checkbox"/> NAUSEA <input type="checkbox"/> RADIATING <input type="checkbox"/> RINGING IN EARS	<input type="checkbox"/> SLEEP DISTURBANCE <input type="checkbox"/> STIFFNESS							
QUALITY OF HEADACHES:	<input type="checkbox"/> DULL <input type="checkbox"/> SHARP	<input type="checkbox"/> THROBBING <input type="checkbox"/> STABBING	<input type="checkbox"/> AURA <input type="checkbox"/> NO AURA	<input type="checkbox"/> RADIATION: <input type="checkbox"/> WEAKNESS:	<input type="checkbox"/> LEFT <input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT <input type="checkbox"/> RIGHT	<input type="checkbox"/> BILATERAL <input type="checkbox"/> BILATERAL				
OTHER ASSOC. SIGNS & SYMPTOMS:	<input type="checkbox"/> ACHES <input type="checkbox"/> COLD LIMB <input type="checkbox"/> DIZZINESS <input type="checkbox"/> FATIGUE	<input type="checkbox"/> FEVER <input type="checkbox"/> HEARTBURN <input type="checkbox"/> MUSCLE SPASM <input type="checkbox"/> NAUSEA	<input type="checkbox"/> NUMBNESS <input type="checkbox"/> PALE BLUISH SKIN <input type="checkbox"/> PANIC <input type="checkbox"/> PINS & NEEDLES	<input type="checkbox"/> RUNNY NOSE <input type="checkbox"/> STIFFNESS <input type="checkbox"/> SWEATING <input type="checkbox"/> SWELLING	<input type="checkbox"/> TINGLING <input type="checkbox"/> VOMITING <input type="checkbox"/> WEAKNESS						
MODIFYING FACTORS – SYMPTOMS BETTER WITH:	<input type="checkbox"/> ACTIVITY <input type="checkbox"/> BENDING	<input type="checkbox"/> COLD <input type="checkbox"/> HEAT	<input type="checkbox"/> MASSAGE <input checked="" type="checkbox"/> MOVEMENT	<input type="checkbox"/> OTC MEDS <input type="checkbox"/> RX MEDS	<input type="checkbox"/> REST <input type="checkbox"/> STRETCHING	<input type="checkbox"/> SITTING <input type="checkbox"/> STANDING	<input type="checkbox"/> TWISTING <input type="checkbox"/> WALKING	<input type="checkbox"/> NOTHING HELPS			
SINCE CONDITION BEGAN, HAS ANYTHING PERMANENTLY HELPED YOU?	<input type="checkbox"/> YES <input type="checkbox"/> NO										
HAS ANYTHING THAT YOU HAVE DONE, THUS FAR, FIXED YOUR PROBLEM	<input type="checkbox"/> YES <input type="checkbox"/> NO										
EMPLOYMENT											
OCCUPATION:				WORK (HRS/DAY):							
JOB CLASSIFICATION:	<input type="checkbox"/> SITTING	<input type="checkbox"/> LIGHT	<input type="checkbox"/> MODERATE	<input type="checkbox"/> HEAVY LIFTING	LIFTING FREQUENCY:	<input type="checkbox"/> CONSTANT (66-100% DAY)	<input type="checkbox"/> FREQUENT (33-65% DAY)	<input type="checkbox"/> OCCASIONAL (0-32% DAY)			
WORK ACTIVITY POSTURES: (HRS/DAY)	<input type="checkbox"/> SITTING <input type="checkbox"/> STANDING	<input type="checkbox"/> WALKING <input type="checkbox"/> CLIMBING	<input type="checkbox"/> PUSHING <input type="checkbox"/> PULLING	<input type="checkbox"/> KNEELING <input type="checkbox"/> REACHING	<input type="checkbox"/> TWISTING <input type="checkbox"/> BENDING						
REPETITIVE ACTIVITIES: (HRS/DAY)	<input type="checkbox"/> COMPUTER <input type="checkbox"/> PHONE		<input type="checkbox"/> MACHINERY <input type="checkbox"/> HAND TOOLS	<input type="checkbox"/> ASSEMBLY <input type="checkbox"/> GRASPING							
HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE:	<input type="checkbox"/> MILD PAINFUL (CAN DO) <input type="checkbox"/> MODERATE PAINFUL (LIMITED)					<input type="checkbox"/> SEVERE (UNABLE TO PERFORM) <input type="checkbox"/> OTHER (EXPLAIN)					

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:											

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: <input type="checkbox"/> I DENY ANY CONST. ISSUE(S)	<input type="checkbox"/> CHILLS <input type="checkbox"/> NIGHT SWEATS	<input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER	<input type="checkbox"/> DAYTIME SOMNOLENCE (DROWSINESS)
EYE/VISION: <input type="checkbox"/> I DENY ANY EYE/VISION ISSUE(S)	<input type="checkbox"/> BLINDNESS <input type="checkbox"/> DOUBLE VISION	<input type="checkbox"/> EYE PAIN <input type="checkbox"/> PHOTOPHOBIA	<input type="checkbox"/> TEARING <input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> FIELD CUTS (VISUAL FIELD DEFECT) <input type="checkbox"/> CATARACTS <input type="checkbox"/> GLAUCOMA
EARS, NOSE, & THROAT: <input type="checkbox"/> I DENY ANY E/N/T ISSUE(S)	<input type="checkbox"/> BLEEDING <input type="checkbox"/> DISCHARGE <input type="checkbox"/> DIZZINESS <input type="checkbox"/> SNORING	<input type="checkbox"/> FAINTING <input type="checkbox"/> HEADACHES <input type="checkbox"/> LOSS OF SMELL <input type="checkbox"/> SORE THROATS (FREQUENT)	<input type="checkbox"/> NASAL CONGESTION <input type="checkbox"/> SINUS INFECTIONS <input type="checkbox"/> DENTAL IMPLANTS	<input type="checkbox"/> EAR DRAINAGE <input type="checkbox"/> EAR INFECTION(S) <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> TINNITUS (RIGHT IN EARS)
RESPIRATION: <input type="checkbox"/> I DENY ANY RESPIRATORY ISSUE(S)	<input type="checkbox"/> ASTHMA <input type="checkbox"/> COUGHING UP BLOOD	<input type="checkbox"/> SPUTUM PRODUCTION	<input type="checkbox"/> COUGH	<input type="checkbox"/> POST NASAL DRIP <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> EAR PAIN <input type="checkbox"/> SHORTNESS OF BREATH
CARDIOVASCULAR: <input type="checkbox"/> I DENY ANY CARDIO. ISSUE(S)	<input type="checkbox"/> ANGINA (CHEST PAIN OR DISCOMFORT) <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> CLAUDICATION (LEG PAIN OR ACHINESS)	<input type="checkbox"/> HEART MURMUR <input type="checkbox"/> HEART PROBLEMS <input type="checkbox"/> ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN)	<input type="checkbox"/> PALPITATIONS (IRREGULAR OR FORCEFUL BREATHING OF THE HEART) <input type="checkbox"/> PAROXYSMAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH)	<input type="checkbox"/> SWELLING OF LEGS <input type="checkbox"/> ULCERS <input type="checkbox"/> VARICOSE VEINS
GASTROINTESTINAL: <input type="checkbox"/> I DENY ANY GI ISSUE(S)	<input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> BELCHING <input type="checkbox"/> BLACK, TARRY STOOLS <input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> DIARRHEA <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> HEARTBURN <input type="checkbox"/> HEMORRHOIDS	<input type="checkbox"/> INDIGESTION <input type="checkbox"/> JAUNDICE (YELLOWING OF SKIN) <input type="checkbox"/> NAUSEA <input type="checkbox"/> RECTAL BLEEDING	<input type="checkbox"/> ABNORMAL STOOL CALIBER (QUALITY) <input type="checkbox"/> ABNORMAL STOOL COLOR <input type="checkbox"/> ABNORMAL STOOL CONSISTENCY

FEMALE: <input type="checkbox"/> I DENY ANY FEMALE ISSUE(S)	<input type="checkbox"/> BIRTH CONTROL THERAPY <input type="checkbox"/> BREAST LUMP/PAIN <input type="checkbox"/> BURNING URINATION	<input type="checkbox"/> CRAMPS <input type="checkbox"/> FREQUENT URINATION <input type="checkbox"/> HORMONE THERAPY	<input type="checkbox"/> IRREGULAR MENSTRUATION <input type="checkbox"/> URINE RETENTION <input type="checkbox"/> VAGINAL BLEEDING	<input type="checkbox"/> VAGINAL DISCHARGE		
MALE: <input type="checkbox"/> I DENY ANY MALE ISSUE(S)	<input type="checkbox"/> BURNING URINATION <input type="checkbox"/> PROSTATE PROBLEMS	<input type="checkbox"/> ERECTILE DYSFUNCTION	<input type="checkbox"/> FREQUENT URINATION <input type="checkbox"/> URINATION RETENTION	<input type="checkbox"/> HESITANCY/DRIBBLING		
ENDOCRINE: <input type="checkbox"/> I DENY ANY ENDOCRINE ISSUE(S)	<input type="checkbox"/> COLD INTOLERANCE <input type="checkbox"/> DIABETES	<input type="checkbox"/> EXCESSIVE APPETITE <input type="checkbox"/> EXCESSIVE HUNGER	<input type="checkbox"/> EXCESSIVE THIRST <input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> GOITER <input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> UNUSUAL HAIR GROWTH	<input type="checkbox"/> VOICE CHANGES
SKIN: <input type="checkbox"/> I DENY ANY SKIN ISSUE(S)	<input type="checkbox"/> CHANGES IN NAIL TEXTURE <input type="checkbox"/> CHANGES IN SKIN COLOR	<input type="checkbox"/> HAIR GROWTH <input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HIVES <input type="checkbox"/> ITCHING	<input type="checkbox"/> PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING)	<input type="checkbox"/> RASH <input type="checkbox"/> HISTORY OF SKIN DISORDERS	<input type="checkbox"/> SKIN LESIONS /ULCERS <input type="checkbox"/> VARICOSITIES
NERVOUS SYSTEMS: <input type="checkbox"/> I DENY ANY NS ISSUE(S)	<input type="checkbox"/> DIZZINESS <input type="checkbox"/> FACIAL WEAKNESS	<input type="checkbox"/> HEADACHES <input type="checkbox"/> LIMB WEAKNESS	<input type="checkbox"/> LOSS OF CONSCIOUSNESS <input type="checkbox"/> LOSS OF MEMORY	<input type="checkbox"/> NUMBNESS <input type="checkbox"/> SEIZURES	<input type="checkbox"/> SLEEP DISTURBANCE <input type="checkbox"/> STRESS	<input type="checkbox"/> STROKES <input type="checkbox"/> TREMORS <input type="checkbox"/> UNSTEADINESS OF GAIT
PSYCHOLOGICAL: <input type="checkbox"/> I DENY ANY PSYCHOLOGICAL ISSUE(S)	<input type="checkbox"/> ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE)	<input type="checkbox"/> ANXIETY <input type="checkbox"/> APPETITE CHANGES	<input type="checkbox"/> BEHAVIORAL CHANGE(S) <input type="checkbox"/> BIPOLAR DISORDER	<input type="checkbox"/> CONFUSION <input type="checkbox"/> CONVULSIONS	<input type="checkbox"/> DEPRESSION <input type="checkbox"/> INSOMNIA	<input type="checkbox"/> MEMORY LOSS <input type="checkbox"/> MOOD CHANGES
ALLERGY: <input type="checkbox"/> I DENY ANY ALLERGY ISSUE(S)	<input type="checkbox"/> ANAPHYLAXIS (HISTORY OF SNEEZING)	<input type="checkbox"/> FOOD INTOLERANCE	<input type="checkbox"/> ITCHING <input type="checkbox"/> NASAL CONGESTION	<input type="checkbox"/> SNEEZING		
HEMATOLOGY: <input type="checkbox"/> I DENY ANY HEMATOLOGY ISSUE(S)	<input type="checkbox"/> ANEMIA <input type="checkbox"/> BLEEDING	<input type="checkbox"/> BLOOD CLOTTING <input type="checkbox"/> BLOOD TRANSFUSION(S)	<input type="checkbox"/> BRUISES EASILY <input type="checkbox"/> FATIGUE	<input type="checkbox"/> LYMPH NODE SWELLING		
PAST HEALTH HISTORY – PLEASE FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.						
CHILDHOOD ILLNESS: <input type="checkbox"/> I DENY ANY CHILDHOOD ILLNESS(ES)	<input type="checkbox"/> ADD <input type="checkbox"/> ALLERGIES/HAYFEVER <input type="checkbox"/> ASTHMA <input type="checkbox"/> ATOPIC DERMATITIS (ECZEMA)	<input type="checkbox"/> BED WETTING <input type="checkbox"/> CEREBRAL PALSY <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> DEPRESSION	<input type="checkbox"/> DIABETES <input type="checkbox"/> EAR INFECTIONS <input type="checkbox"/> FETAL DRUG EXPOSURE <input type="checkbox"/> HEPATITIS <input type="checkbox"/> HIV	<input type="checkbox"/> FOOD ALLERGIES <input type="checkbox"/> HEADACHES <input type="checkbox"/> HEPATITIS <input type="checkbox"/> HIV	<input type="checkbox"/> MEASLES <input type="checkbox"/> MUMPS <input type="checkbox"/> RASH <input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/> SICKLE CELL ANEMIA <input type="checkbox"/> SPINA BIFIDA <input type="checkbox"/> OTHER (PLEASE DESCRIBE)
ADULT ILLNESS: <input type="checkbox"/> I DENY ANY ADULT ILLNESS(ES)	<input type="checkbox"/> ALZHEIMERS <input type="checkbox"/> ANEMIA <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> ASTHMA <input type="checkbox"/> CANCER <input type="checkbox"/> CHICKEN BOX <input type="checkbox"/> CHRON'S/COLITIS <input type="checkbox"/> CRPS (RSD)	<input type="checkbox"/> CVA (STROKE) <input type="checkbox"/> CYSTIC KIDNEY DISEASE <input type="checkbox"/> DEPRESSION <input type="checkbox"/> DIABETES (INSULIN) <input type="checkbox"/> DIABETES (NON INSULIN) <input type="checkbox"/> EAR INFECTIONS (FREQUENT) <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> EYE PROBLEMS	<input type="checkbox"/> FIBROMYALGIA <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> HEPATITIS <input type="checkbox"/> HIV <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> INFLUENZA <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> LUNG DISEASE	<input type="checkbox"/> LUPUS ERYTHEMA (DISCOID) <input type="checkbox"/> LUPUS ERYTHEMA (SYSTEMIC) <input type="checkbox"/> MULTIPLE SCLEROSIS <input type="checkbox"/> PARKINSON'S DISEASE <input type="checkbox"/> PLEURISY <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> PSYCHIATRIC PROBLEMS <input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/> SHINGLES <input type="checkbox"/> STD'S (UNSPECIFIED) <input type="checkbox"/> SUICIDE ATTEMPT(S) <input type="checkbox"/> THYROID PROBLEMS <input type="checkbox"/> VERTIGO <input type="checkbox"/> PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION	<input type="checkbox"/> OTHER _____
SURGERIES: <input type="checkbox"/> I DENY ANY SURGERY (IES)	<input type="checkbox"/> ANGIOPLASTY <input type="checkbox"/> APPENDECTOMY <input type="checkbox"/> CAESAREAN SECTION <input type="checkbox"/> CARDIAC CATHETERIZATION <input type="checkbox"/> CARPAL TUNNEL REPAIR	<input type="checkbox"/> CORONARY ARTERY BYPASS <input type="checkbox"/> COSMETIC <input type="checkbox"/> D & C <input type="checkbox"/> DENTAL SURGERY <input type="checkbox"/> GALL BLADDER	<input type="checkbox"/> HEMORRHOIDECTOMY <input type="checkbox"/> HERNIA REPAIR <input type="checkbox"/> HYSTERECTOMY <input type="checkbox"/> JOINT RECONSTRUCTION <input type="checkbox"/> JOINT REPLACEMENT	<input type="checkbox"/> LAMINECTOMY <input type="checkbox"/> MASTECTOMY <input type="checkbox"/> PACEMAKER INSERTION <input type="checkbox"/> ROTATOR CUFF <input type="checkbox"/> SPINAL FUSION	<input type="checkbox"/> TONSILLECTOMY <input type="checkbox"/> OTHER	
OB/GYN: <input type="checkbox"/> I DENY ANY OB/GYN ISSUES	<input type="checkbox"/> I HAVE NEVER BEEN PREGNANT <input type="checkbox"/> I HAVE BEEN PREGNANT IN THE PAST <input type="checkbox"/> I AM CURRENTLY PREGNANT	MENSTRUAL HISTORY: AGE OF ONSET _____	<input type="checkbox"/> MY MENSES IS REGULAR <input type="checkbox"/> MY MENSES IS IRREGULAR <input type="checkbox"/> I AM CURRENTLY IN MENOPAUSE	DATE OF LAST MENSES ____/____/____		
INJURIES: <input type="checkbox"/> I DENY ANY INJURY (IES)	<input type="checkbox"/> BACK INJURY <input type="checkbox"/> BROKEN BONES <input type="checkbox"/> SEVERE FALL	<input type="checkbox"/> FRACTURE <input type="checkbox"/> DISABILITY <input type="checkbox"/> HEAD INJURY	<input type="checkbox"/> INDUSTRIAL ACCIDENT <input type="checkbox"/> JOINT INJURY <input type="checkbox"/> SEVERE LACERATION	<input type="checkbox"/> MOTOR VEHICLE ACCIDENT <input type="checkbox"/> MILD/MODERATE SOFT TISSUE INJURY <input type="checkbox"/> SEVERE SOFT TISSUE INJURY		
IMMUNIZATIONS: <input type="checkbox"/> I DENY ANY IMMUNIZATION(S)	<input type="checkbox"/> DTAP (DIPHTHERIA, TETANUS & PERTUSSIS)	<input type="checkbox"/> FLU <input type="checkbox"/> HEPATITIS A <input type="checkbox"/> HEPATITIS B	<input type="checkbox"/> HEPATITIS C <input type="checkbox"/> INFLUENZA <input type="checkbox"/> IPV (POLIO) <input type="checkbox"/> PNEUMOCOCCAL <input type="checkbox"/> PPD (MANTOUX TEST-TB)	<input type="checkbox"/> MMR (MEASLES, MUMPS, & RUBELLA) <input type="checkbox"/> PNEUMOCOCCAL <input type="checkbox"/> PPD (MANTOUX TEST-TB)	<input type="checkbox"/> SMALL POX <input type="checkbox"/> TB <input type="checkbox"/> VARIVAX (CHICKEN POX)	<input type="checkbox"/> WHOOPING COUGH (PERTUSSIS)
NON-DRUG ALLERGIES: <input type="checkbox"/> I DENY ANY NON-DRUG ALLERGIES	<input type="checkbox"/> ANIMALS	<input type="checkbox"/> DAIRY	<input type="checkbox"/> EGGS	<input type="checkbox"/> FOOD COLORING	<input type="checkbox"/> MOLD	<input type="checkbox"/> POLLEN

PREVIOUS TREATMENT

PREVIOUS CHIROPRACTIC CARE? <input type="checkbox"/> YES IF YES, WHO? (NAME) <input type="checkbox"/> NO			
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES IF YES, WHO? (NAME) <input type="checkbox"/> NO	LOCATION OF OFFICE:	TYPE OF TREATMENT:	
WERE YOU SATISFIED WITH THE RESULTS OF YOUR TREATMENT? <input type="checkbox"/> YES EXPLAIN: <input type="checkbox"/> NO			
ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS? <input type="checkbox"/> YES IF YES, PLEASE MARK OR LIST (BE SPECIFIC) <input type="checkbox"/> NO	<input type="checkbox"/> ALLERGY MEDICATION <input type="checkbox"/> ANTI-DEPRESSANTS	<input type="checkbox"/> BLOOD PRESSURE MEDS. <input type="checkbox"/> INSULIN	<input type="checkbox"/> MUSCLE RELAXERS <input type="checkbox"/> NERVE PILLS <input type="checkbox"/> PAIN KILLERS <input type="checkbox"/> OTHER (PLEASE SPECIFY)
DO YOU WEAR ANY OF THE FOLLOWING? <input type="checkbox"/> HEAL LIFTS <input type="checkbox"/> INNER SOLES	<input type="checkbox"/> ARCH SUPPORTS <input type="checkbox"/> 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 GRANDMOTHER	___ MATERNAL GRANDMOTHER	___ DAUGHTER(S)	___ SISTER(S)
	___ PATERNAL GRANDFATHER	___ MATERNAL GRANDFATHER	___ SON(S)	___ BROTHER(S)	

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

SOCIAL HISTORY

ALCOHOL: <input type="checkbox"/> NEVER <input type="checkbox"/> SOCIAL <input type="checkbox"/> BEER <input type="checkbox"/> LIQUOR <input type="checkbox"/> WINE <input type="checkbox"/> DAILY CONSUMPTION ONLY <input type="checkbox"/> WEEKLY ONLY <input type="checkbox"/> MONTHLY	OZ.'S # GLASSES _____	DIET: MARK ALL THAT APPLY <input type="checkbox"/> HIGH FAT <input type="checkbox"/> HIGH FIBER <input type="checkbox"/> HIGH PROTEIN <input type="checkbox"/> HIGH SALT	<input type="checkbox"/> LOW CALORIE <input type="checkbox"/> LOW CARB <input type="checkbox"/> LOW SUGAR	<input type="checkbox"/> LOW FIBER <input type="checkbox"/> LOW SALT	# PER: <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH	<input type="checkbox"/> # CHEW _____

PLEASE 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: