

Patient History

Name: _____ Address _____

City: _____ State: _____ Zip Code _____

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

Social Security#: _____ Drivers License # _____

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

Employer: _____ Type of Work: _____

Work Phone: _____ Spouses Social Security # _____

Spouse Name: _____ Spouses Insurance # _____

Spouse Employer: _____ Business Phone: _____

Type of Work: _____ Name & Ages of Children: _____

Referred to this office by: _____

Name & Number of Emergency Contact: _____

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

E-mail Address _____ Cell Phone: _____

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? Yes No

What drugs to you take? Nerve Pills/Anti-Depressants 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: No Yes Doctor's Name & Last visit date: _____

Below is a list of diseases that 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:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you tested positive for HIV? Yes No

Check any of the following you have had in the past 6 months:

MUSCULO-SKELETAL

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Black/Bloody Stool |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Joint Pain/Stiffness | |
| <input type="checkbox"/> Walking Problems | |
| <input type="checkbox"/> Difficult Chewing/Jaw Clicks | |
| <input type="checkbox"/> General Stiffness | |

FEMALES ONLY

When was you last period? _____
Are you pregnant?
 Yes No Not Sure

NERVOUS SYSTEM

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

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIO- PULMONARY

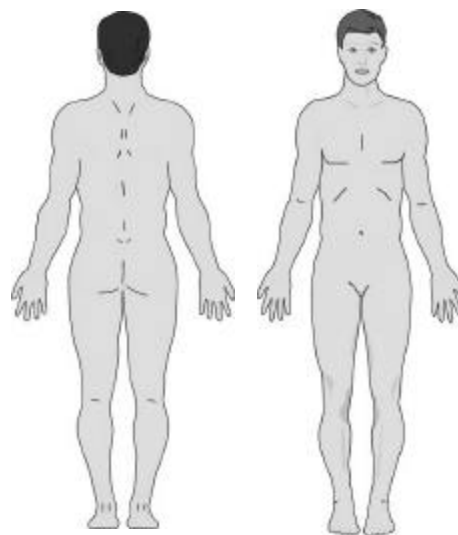
- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heart Beat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT

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



Please outline on the above diagram the area(s) of discomfort.

GASTRO-INTESTINAL

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

MALE/FEMALE

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

FAMILY HISTORY

- The following family members have the same or similar problem as I do:
- Mother
 - Father
 - Brother
 - Sister
 - Spouse
 - Child

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 below:

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.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
 Signature Authorizing Care _____ Date _____

Do Not Write Below This Line

Diagnosis:

Analysis: _____

Patient Accepted: Yes No

Doctor's Signature _____