

## ABOUT YOU

Today's Date: \_\_\_\_\_ Case: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

What you prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Children: \_\_\_\_\_ Pregnant?  Yes  No. If yes, \_\_\_\_\_ Months

Spouse's Name (or next of kin): \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Medical Physician's Name: \_\_\_\_\_

Other Physicians Treating You at This Time: \_\_\_\_\_

Dominance:  Right Handed  Left Handed  Ambidextrous

## ACCOUNT INFORMATION

**Person ultimately responsible for account if other than self.**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Drivers License#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Group# (Plan, Local or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

**Please inform front desk of second insurance source.**

- We invite you to discuss with us any question regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item, enter (Y) if you have EVER HAD the problem, enter (N) if you have NEVER HAD the problem or enter (YN) if you are CURRENTLY HAVING the problem.

## General

1. \_\_\_ Fever
2. \_\_\_ Chills
3. \_\_\_ Night Sweats
4. \_\_\_ Loss of Sleep
5. \_\_\_ Fatigue
6. \_\_\_ Nervousness
7. \_\_\_ Weight Loss or Gain
8. \_\_\_ Allergies
9. \_\_\_ Bleeding Problems
10. \_\_\_ Anemia
11. \_\_\_ Diabetes
12. \_\_\_ Cancer
13. \_\_\_ Thyroid Disease/Goiter
14. \_\_\_ Alcoholism
15. \_\_\_ Drug Abuse

## Ear, Eye, Nose, Throat

16. \_\_\_ Poor Vision
17. \_\_\_ Pain in Eye(s)
18. \_\_\_ Deafness/Difficulty Hearing
19. \_\_\_ Nosebleeds
20. \_\_\_ Nose Problems
21. \_\_\_ Sinus Trouble
22. \_\_\_ Dental Problems
23. \_\_\_ Horseness
24. \_\_\_ Tonsillectomy

## Gastrointestinal

25. \_\_\_ Poor Appetite
26. \_\_\_ Poor Digestion
27. \_\_\_ Difficulty Swallowing
28. \_\_\_ Belching or Gas
29. \_\_\_ Frequent Nausea
30. \_\_\_ Vomiting
31. \_\_\_ Vomiting Blood
32. \_\_\_ Pain Over Abdomen
33. \_\_\_ Ulcer
34. \_\_\_ Black or Bloody Stool
35. \_\_\_ Liver Problems
36. \_\_\_ Gall Bladder Problems
37. \_\_\_ Jaundice
38. \_\_\_ Hernia
39. \_\_\_ Diarrhea
40. \_\_\_ Constipation
41. \_\_\_ Hemorrhoids
42. \_\_\_ Appendicitis

## Men Only

43. \_\_\_ Testicular Swelling/Pain
44. \_\_\_ Prostate Problems

## Respiratory

45. \_\_\_ Difficulty in Breathing
46. \_\_\_ Chronic Cough
47. \_\_\_ Spitting Phlegm
48. \_\_\_ Spitting Blood
49. \_\_\_ Wheezing/Asthma
50. \_\_\_ Pneumonia
51. \_\_\_ Tuberculosis

## Cardiovascular

52. \_\_\_ Irregular Heartbeat
53. \_\_\_ High Blood Pressure
54. \_\_\_ Pain Over Heart
55. \_\_\_ Previous Heart
56. \_\_\_ Ankle Swelling
57. \_\_\_ Varicose Veins
58. \_\_\_ Rheumatic Fever
59. \_\_\_ Stroke

## Genitourinary

60. \_\_\_ Frequent Urination
61. \_\_\_ Painful Urination
62. \_\_\_ Blood in Urine
63. \_\_\_ Kidney Disease
64. \_\_\_ Urinary Infection
65. \_\_\_ Inability to Control Urination
66. \_\_\_ Difficulty Starting Urine Flow
67. \_\_\_ Get Up at Night to Urinate
68. \_\_\_ Breast Lump
69. \_\_\_ Venereal Infection
70. \_\_\_ Sexual Difficulties

## Skin

71. \_\_\_ Itching
72. \_\_\_ Bruising Easily
73. \_\_\_ Change in Mole(s)
74. \_\_\_ Skin Cancer
75. \_\_\_ Scars Location

## Neurologic

76. \_\_\_ Weakness
77. \_\_\_ Twitching
78. \_\_\_ Tremors
79. \_\_\_ Headache
80. \_\_\_ Fainting
81. \_\_\_ Dizziness
82. \_\_\_ Convulsions
83. \_\_\_ Epilepsy/Seizures
84. \_\_\_ Numbing/Tingling
85. \_\_\_ Arm/Leg Pain
86. \_\_\_ Mental Disorder

## Musculoskeletal

87. \_\_\_ Neck Stiffness/Pain
88. \_\_\_ Pain Between Shoulders
89. \_\_\_ Low Back Pain
90. \_\_\_ Swollen Joints
91. \_\_\_ Painful Joints
92. \_\_\_ Muscle Aches/Soreness
93. \_\_\_ Arthritis

## Women Only

94. \_\_\_ Painful Periods
95. \_\_\_ Excessive Flow
96. \_\_\_ Irregular Cycles
97. \_\_\_ Vaginal Burning/Itching
98. \_\_\_ Hot Flashes
99. \_\_\_ Date Last Period Began
100. \_\_\_ Date of Last Pap Smear

## Exercise

101. \_\_\_ None
102. \_\_\_ 1-2 Times/Week
103. \_\_\_ 3-5 Times/Week
104. \_\_\_ 6-7 Times/Week

## Habits

105. \_\_\_ Smoking #Packs/Day \_\_\_\_\_
106. \_\_\_ Alcohol
107. \_\_\_ Recreational Drug Use
108. \_\_\_ Caffeine

## Family History

Do not include yourself!  
(Include information on brothers, sisters, parents, and grandparents)

109. \_\_\_ Diabetes
110. \_\_\_ Thyroid Disease/Goiter
111. \_\_\_ Tuberculosis
112. \_\_\_ Kidney Disease
113. \_\_\_ High Blood Pressure
114. \_\_\_ Heart Disease
115. \_\_\_ Cancer
116. \_\_\_ Muscle, Bone or Nerve Disease
117. \_\_\_ Lung Disease
118. \_\_\_ Ulcers
119. \_\_\_ Arthritis
120. \_\_\_ Seizures/Stroke

## Miscellaneous

\_\_\_\_\_  
Patient's Signature

## HEALTH HISTORY 2

Are you taking any of the following medications?

Nerve pills  Pain killers (including aspirin)  Muscle relaxers  Stimulants  Blood thinners  Tranquilizers  Insulin

Others(s): \_\_\_\_\_

Please list names of medications / supplements you are taking: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

List all previous surgeries/treatments with dates: \_\_\_\_\_

List any and all accidents with dates: \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports  Custom made orthotics

What is the age of your mattress? \_\_\_\_\_ Is it comfortable?  Yes  No

**For women:** Are you taking birth control?  Yes  No

Are you pregnant?  No  Yes / How long? \_\_\_\_\_ Nursing?  Yes  No

## REASON FOR VISIT

Have you had previous chiropractic care?  Yes  No Name of chiroprator(s): \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Other complaints: \_\_\_\_\_

How did condition develop? \_\_\_\_\_

Date of onset: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Have you had same or similar problems in the past?  Yes  No When? \_\_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

How long has it been since you really felt good? \_\_\_\_\_

What aggravates condition? \_\_\_\_\_ Does anything offer relief? \_\_\_\_\_

How would you describe discomfort?  Sharp  Dull  Achy  Throbbing  Other \_\_\_\_\_

What percent of time does this condition bother you?  0%  25%  50%  75%  100% Time of day? \_\_\_\_\_

How would you rate the level of discomfort on a scale of 0-10 (0=no pain 10=extreme pain)? \_\_\_\_\_



## COMPLAINT 3

NO PAIN EXTREME PAIN

**Complaint:** \_\_\_\_\_ **Grade:** 0 1 2 3 4 5 6 7 8 9 10

**Came on:**  Gradually  Immediately **It is getting:**  Better  Same  Worse **Intensity:**  Minimal  Slight  Moderate  Severe **Frequency:**  Intermittent  Occasional  Frequent  Constant

Duration \_\_\_\_\_

**Describe Feeling:**  Dull  Sharp  Aching  Shooting  Spasm  Throbbing  Burning  
 Numbing  Tingling  
 Other \_\_\_\_\_

**Location:**  Right  Left  Antero-Lateral  Postero-Lateral

**Action Affecting This Pain: (B) Brings On (A) Aggravates (R) Relieves**

In the Morning: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	In the Afternoon: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Forward: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Bending Back: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Twisting Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Twisting Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Coughing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Sneezing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Straining: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Standing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Lifting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Sitting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Heat: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Cold: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Rest: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Lying Down: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Medications: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

Nothing relieves the pain      Other 1: \_\_\_\_\_ B A R  
Other 1: \_\_\_\_\_ B A R

**Pain Radiates To:**

Head: <input type="checkbox"/> Right <input type="checkbox"/> Left	Neck: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
Leg: <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot: <input type="checkbox"/> Right <input type="checkbox"/> Left	

Pain also radiates to: \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

## COMPLAINT 4

NO PAIN EXTREME PAIN

**Complaint:** \_\_\_\_\_ **Grade:** 0 1 2 3 4 5 6 7 8 9 10

**Came on:**  Gradually  Immediately **It is getting:**  Better  Same  Worse **Intensity:**  Minimal  Slight  Moderate  Severe **Frequency:**  Intermittent  Occasional  Frequent  Constant

Duration \_\_\_\_\_

**Describe Feeling:**  Dull  Sharp  Aching  Shooting  Spasm  Throbbing  Burning  
 Numbing  Tingling  
 Other \_\_\_\_\_

**Location:**  Right  Left  Antero-Lateral  Postero-Lateral

**Action Affecting This Pain: (B) Brings On (A) Aggravates (R) Relieves**

In the Morning: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	In the Afternoon: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Forward: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Bending Back: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Twisting Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Twisting Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Coughing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Sneezing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Straining: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Standing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Lifting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Sitting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Heat: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Cold: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Rest: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Lying Down: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Medications: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

Nothing relieves the pain      Other 1: \_\_\_\_\_ B A R  
Other 1: \_\_\_\_\_ B A R

**Pain Radiates To:**

Head: <input type="checkbox"/> Right <input type="checkbox"/> Left	Neck: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
Leg: <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot: <input type="checkbox"/> Right <input type="checkbox"/> Left	

Pain also radiates to: \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_