

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:	
Address:			
Street	City	State	Zip
Home phone:		Work phone:	
Cell phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Height:		Weight:	
Marital status: M S W D		Spouse/guardian name:	
Occupation:			
Employer:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Insurance Company:			
Insurance Policy number:		Insurance Company phone number:	
Insurance Company address:			

Who may we thank for referring you?

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **“General Health History”**.

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition?

Other doctors you have seen for this condition:

“Limited Scope” Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
“Wellness” Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor’s details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes	No	Maybe
If dietary changes are indicated would you be willing to make changes in your diet?	Yes	No	Maybe
Would you take whole food supplements if indicated?	Yes	No	Maybe
If specific exercises or stretching would help would you consider adding them to your program?	Yes	No	Maybe
If reducing stress would help you would you like to know ways to reduce stress?	Yes	No	Maybe

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily **W** - Consume weekly **M** - Consume this monthly **X** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 please grade your present levels of stress 1 being little to no stress 10 being extreme stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Past Health History

Often seemingly unrelated symptoms can manifest as other health concerns:

(Please circle if you have had any of the following)

Headaches	Irritability	Stroke	Pneumonia
Heartburn	Depression	Cancer	Difficulty Breathing
Upper Back pain	Loss of Balance	Multiple Sclerosis	Asthma
Neck pain	Loss of Concentration	Thyroid Problems	Urinary Problems
Lower Back pain	Loss of Memory	Heart Attack	Constipation
Stiffness	Ear buzzing	Heart Disease	Diarrhea
Reduced Mobility	Poor coordination	Measles	Weight Loss
Numbness in leg(s)	Vision changes	Ulcers	Weight Gain
Numbness in feet	Loss of smell	Arthritis	Dental Problems
Numbness in hands	Sinus Congestion	High Blood Pressure	Fevers
Weakness	Loss of taste	Menstrual Cramps	Chest Pressure
Muscle Cramps	Light sensitivity	Gall Bladder Problem	Breast Pain
Gas	Diabetes	Migraines	Frequent Colds
Sleeping Problems	Gout	Whooping Cough	Sore Throat
Dizziness	Irregular Periods	Face flushed	Allergies
Fainting	Miscarriage	Bronchitis	Ear Infection/Pain

Other (please explain)

Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

