Patient Health History

Patient Title: ☐ Mr. ☐Mrs. ☐Miss ☐Dr. ☐Prof. ☐Rev.

First Name:_____ Nick Name:_____

Last Name:_____ Middle Name: _____Suffix:_____

Address: _____

City:_____ State: _____ Zip Code:_____

Social Security Number_____ Occupation:_____

Email:_____

Cell Phone #: _____ Home Phone #: _____

Do you prefer text reminders? ☐ Yes ☐ No Phone Service Provider_____

Date of Birth:_____ Age:_____ Gender: ☐ Male ☐ Female ☐ Unspecified

Dominant hand? ☐ Left ☐ Right ☐ Both

Marital Status	Employment Status	Race	Ethnicity
☐ Single ☐ Married ☐ Divorced ☐ Other	☐ Employed ☐ FT Student ☐ PT Student ☐ Retired	☐ White ☐ Black/ African American ☐ Hispanic ☐ Other	☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ I choose not to specify

Preferred Language	Do you currently smoke tobacco products of any kind?	How often do you smoke?	What is your level of interest in quitting smoking?
☐ English ☐ Spanish ☐ Other	☐ Yes ☐ Former Smoker ☐ Never Smoked	☐ Everyday ☐ Sometimes	1-Not interested at all 10- Very Interested 1 2 3 4 5 6 7 8 9 10

Current medications, including frequency and dosage if known.

If there are no current medications, check here: ☐

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any known allergies you have had to medications. If no allergies are known, check here: ☐

1. _____ 2. _____

Has any doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No

If yes, please describe: _____

What Brings You To Our Office?

If you have NO symptoms/complaints and are here for Wellness, please indicate using NONE.

List of Problems/Concerns: (most important first)

1. _____ 2. _____

Frequency of MAIN problem
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

Better
- ☐ in the morning
- ☐ by mid-day
- ☐ by evening
- ☐ at night
- ☐ doesn't change

Relieving Factors
- ☐ sitting
- ☐ standing
- ☐ lying down
- ☐ movement
- ☐ stretching
- ☐ heat
- ☐ ice
- ☐ massage
- ☐ medication

Quality of Pain
- ☐ dull ache
- ☐ sharp
- ☐ burning
- ☐ stiffness
- ☐ numb/tingling
- ☐ radiating

Worse
- ☐ in the morning
- ☐ by mid-day
- ☐ by evening
- ☐ at night
- ☐ doesn't change

Aggravating Factors
- ☐ sitting
- ☐ driving
- ☐ standing
- ☐ bending
- ☐ lifting
- ☐ walking
- ☐ sleeping
- ☐ work activities
- ☐ coughing
- ☐ rest
- ☐ movement
- ☐ exercise
- ☐ stress
- ☐ fatigue
- ☐ household chores

Have you seen other doctors for this problem? ☐No ☐Yes

If yes, what treatment was received and did it help? _____

No Complaints or Problems? Start Here:

Have you seen a chiropractor before ? When? _____
- ☐ Yes
- ☐ No

Do you wear orthotics or arch support?
- ☐ Yes
- ☐ No

How would you rate your mattress?
- ☐ Great
- ☐ OK
- ☐ Need a better one

Sleeping position
- ☐ Side
- ☐ Back
- ☐ Stomach
- ☐ Change positions

How many hours do you sleep on average?
- ☐ 6-8 hours
- ☐ 4-5 hours
- ☐ 2-3 hours

Caffeine Used
- ☐ Often
- ☐ Occasionally
- ☐ Never

Exercise
- ☐ Often
- ☐ Occasionally
- ☐ Never

Alcohol
- ☐ Often
- ☐ Occasionally
- ☐ Never

Feel Stressed
- ☐ Often
- ☐ Occasionally
- ☐ Never

Average daily water intake: _____ oz.

Vitamins/Supplements:

1. _____ 3. _____

2. _____ 4. _____

Your Past Health History

Check all that apply. If you have NO symptoms/complaints please check NONE ☐

Cardiovascular
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Irregular Heartbeat

Genitourinary
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Prostate
- ☐ Frequent Infection
- ☐ Kidney Disease

Blood/Lymph
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Leukemia
- ☐ Blood Clots
- ☐ Hepatitis

Respiratory
- ☐ Asthma
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ TB

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Ringing
- ☐ Chronic Sinus
- ☐ Frequent Ear Infections

Eyes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Double Vision
- ☐ Blindness
- ☐ Detached Retina

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rashes
- ☐ Shingles

Allergy/Immunity
- ☐ Hives
- ☐ HIV/AIDS
- ☐ Allergy Shots
- ☐ Chronic Allergies

Gastrointestinal
- ☐ Gall Bladder
- ☐ Crohn's Disease
- ☐ Constipation
- ☐ Ulcers
- ☐ Reflux
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Poor Appetite
- ☐ Diverticulitis

Musculoskeletal
- ☐ Gout
- ☐ Arthritis
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis

Neurological
- ☐ Seizures
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Autism
- ☐ Memory Loss
- ☐ Severe Headaches/ Migraines
- ☐ Parkinson's
- ☐ Carpal Tunnel
- ☐ Loss of Balance
- ☐ Dizziness

Endocrine
- ☐ Thyroid
- ☐ Diabetes
- ☐ Menopause
- ☐ Menstrual Problems

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Unusual Stress
- ☐ Bi-Polar Disorder

Constitutional
- ☐ Weight loss/ gain
- ☐ Energy Problem
- ☐ Difficulty Sleeping

Allergies
- ☐ Eggs
- ☐ Shellfish
- ☐ Milk/Lactose
- ☐ Peanuts
- ☐ Soy
- ☐ Pets
- ☐ Sulfa
- ☐ Wheat/Gluten
- ☐ Codeine
- ☐ Chemical
- ☐ Seasonal
- ☐ Latex

Surgery History

List any relevant below.

_____

_____

_____

To be performed by clinic staff:

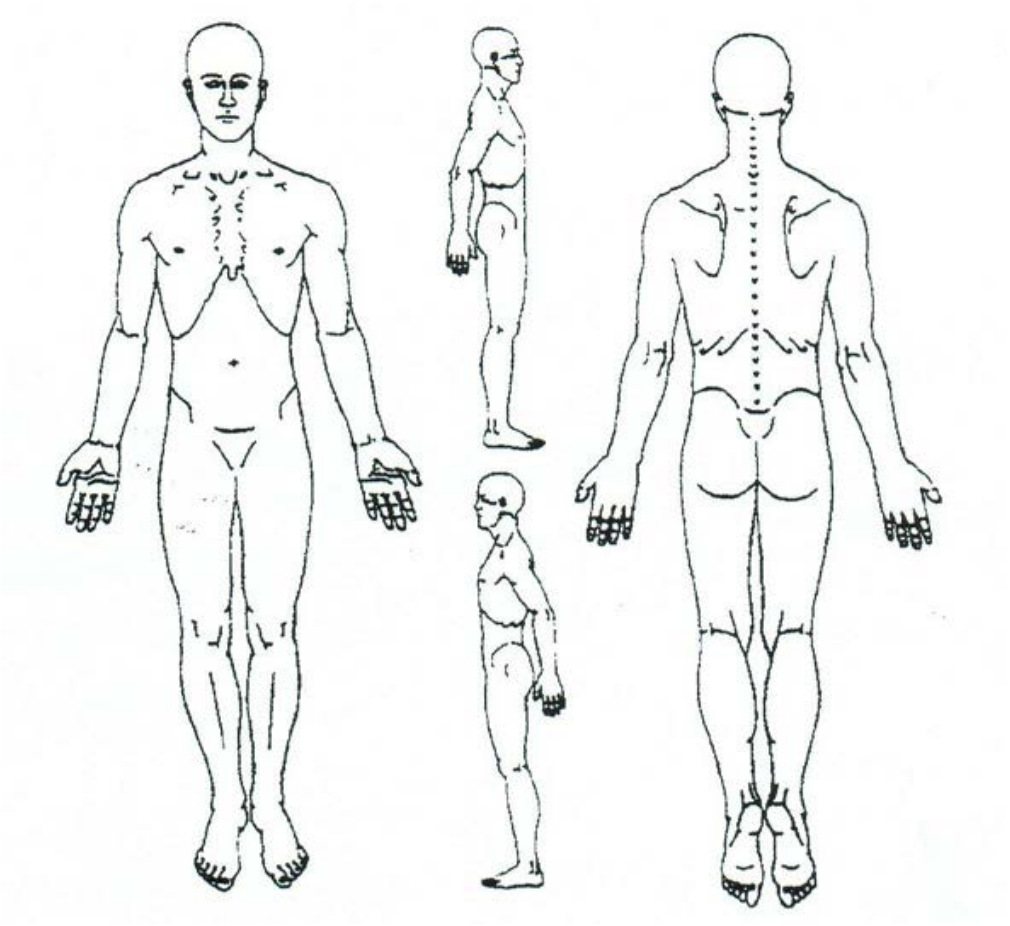
Height:_____ inches Weight_____ pounds BP:_____/_____

Please mark areas on the picture below that correspond to the areas of your body where you feel the described sensations. Mark areas of radiation. Include all affected areas.

Use appropriate symbols:

Numbness - - - - - **Pins & Needles ooooo** **Burning xxxxx**

Aching ***** **Stabbing /////**



VISUAL ANALOG PAIN SEVERITY SCALE

Please place a mark on the line that corresponds to your ***current*** pain.

NO PAIN **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10 WORSE PAIN EVER**

Please place a mark on the line that corresponds to your ***average*** pain

NO PAIN **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10 WORSE PAIN EVER**

PLEASE SIGN

Patient Signature:_____ **Date:**_____

Family Health History

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation of a **C** *under his or her column. The designation of a* **P** *should be used to indicate a past problem. Leave blank those spaces that do not apply.*

	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Allergies						
Anxiety						
Arthritis						
Auto Accident						
Back Pain						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Epilepsy						
Freq. Cold/Flu						
Gassy/Bloating						
Headache						
Heartburn						
Heart Trouble						
High Blood Pressure						
Low Energy						
Migraine						
Neck Pain						
Nervousness						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Sleeping Problems						
Other:						
Other:						
Other:						

The statements made on these forms are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

All fees are payable when services are received unless special arrangements are made in advance.

The purpose of today's visit is to determine if you are a candidate for care in this office.

Patient's Signature:_____ Date:_____

Informed Consent

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare minor fractures, and possible stroke have been associated with chiropractic adjustments.

Patient Signature_____ Date _____

X-Ray Consent

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed necessary in my case.

Patient Signature_____ Date _____

Office Financial Policy

All services rendered are the responsibility of the patient and said patient is ultimately responsible for all payment on services regardless of whether or not this office accepts insurance assignment. Our office will prequalify your insurance coverage. We will give you the best estimate of your coverage for the recommended services. This is **not a guarantee of benefits.** Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero. Any expenses incurred by this office (collections, court fees, etc.)in the effort to obtain payment on unpaid accounts past 90 days will be added to your balance.

Patient Signature_____ Date _____

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment, however, private areas are available upon request. You may refuse to sign this acknowledgement and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

☐ Cell phone ☐ Home phone ☐ Text message

☐ Email ☐ All of the above

Patient Signature_____ Date _____

Witness