

DATE

PERSONAL HISTORY

Name: _____	Address: _____
City: _____	State: _____ Zip/Postal Code: _____
Home Phone: _____	Birth Date: _____ Age: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Cell Phone: _____	E-mail Address: _____
Would you like to receive a text message reminder? <input type="checkbox"/> Y <input type="checkbox"/> N	Would you like to receive our newsletter via email? <input type="checkbox"/> Y <input type="checkbox"/> N
Social Security #: _____	Driver's License #: _____
Medical Insurance #: _____	Married Single Widowed Divorced Separated
Business Employer: _____	Name of Spouse: _____
Business Phone: _____	Spouse Birth Date: _____
Type of Work: _____	Spouse Employer: _____
Is Condition: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Job Related <input type="checkbox"/> Fall	Business Phone: _____
Other: _____	Name and Ages of Children: _____
Referred To This Office By: _____	_____
Name and Number of Emergency Contact: _____	Relationship: _____
Previous Chiropractic Care: <input type="checkbox"/> None <input type="checkbox"/> Doctor's Name & Approximate Date of Last Visit: _____	
Who Is Responsible For Your Bill, You and <input type="checkbox"/> Spouse <input type="checkbox"/> Workers Comp. <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	

CONSENT TO CHIROPRACTIC TREATMENT

I authorize the performance of examination, x-ray (when needed) and chiropractic treatment to be performed by, or under the direction of, Dr. Thomas Gerhard, DC and/or such doctors/paraprofessionals/assistants as may be selected by the doctor to perform such professional procedures, as he deems necessary.

I recognize that during the course of procedure, unforeseen conditions may necessitate additional or different procedures/services than those set forth above and I further authorize and request Dr. Thomas Gerhard, DC to as are in his professional judgment necessary and desirable.

The nature, purpose and possible consequences of the procedures, possible alternative methods or treatment, the risk involved and the possibility of complications perform such procedures have been fully explained to me by my attending Doctor of Chiropractic.

No guarantees or assurances have been made or given by anyone as to the specific results that may be obtained and none are promised.

I, the undersigned, have read and understand the contents of this authorization.

Patient or authorized person signature: _____ Date: _____

Relationship (if other than patient): _____

Below is a list of diseases which may be unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of 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 been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

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

NERVOUS SYSTEM CODE

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

GENERAL CODE

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

GASTRO-INTESTINAL CODE

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

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolor Urine

C-V-R CODE

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

EENT CODE

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

MALE/FEMALE CODE

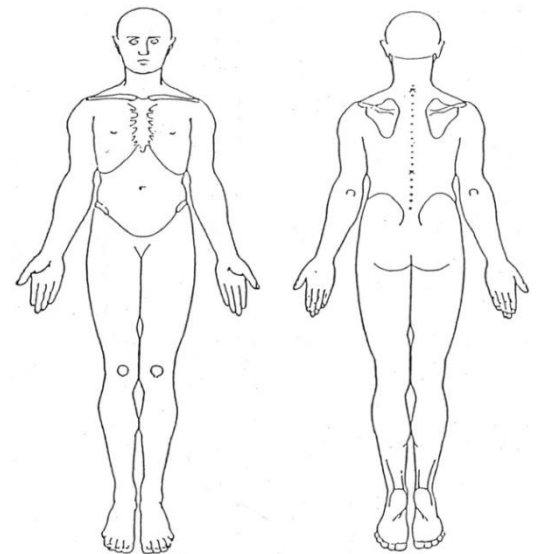
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problems as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature