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## CONFIDENTIAL PATIENT INFORMATION

### Personal Information

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

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):

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Which activities aggravate your condition? \_\_\_\_\_

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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?	

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

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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)

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

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

### Diet

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

**D** - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week  
**FM** - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - 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			

The type of diet I usually follow is classified as: \_\_\_\_\_

### Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping

Other (please explain) \_\_\_\_\_

## 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 (including physical, bio-chemical and psychological or mental/emotional):

At work:

At home:

At play:

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:

How do you grade your physical health?

Excellent

Good

Fair

Poor

Getting better

Getting worse

How do you grade your emotional/mental health?

Excellent

Good

Fair

Poor

Getting better

Getting worse

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: \_\_\_\_\_