NAME:_____ DATE:_____

Constitutional:

	YES	NO
Weight Loss/Gain	___	___
Energy Level Problem	___	___
Loss of Sleeping	___	___
Night Sweats	___	___
Fever	___	___
Chills	___	___

Cardiovascular:

	YES	NO
High Blood Pressure	___	___
Low Blood Pressure	___	___
Aortic Aneurysm	___	___
Heart Disease	___	___
Heart Attack	___	___
Pacemaker	___	___
Swelling of Extremity	___	___

Musculoskeletal:

	YES	NO
Gout	___	___
Arthritis	___	___
Joint Stiffness	___	___
Muscle Weakness	___	___
Osteoporosis	___	___
Broken Bones	___	___
Joints Replaced	___	___

Endocrine:

	YES	NO
Thyroid Disease	___	___
Diabetes	___	___
Hair Loss	___	___
Heat/Cold Intolerance	___	___

Psychiatric:

	YES	NO
Depression	___	___
Anxiety Disorder	___	___
Unusual Stress	___	___
Mood Swings	___	___

Ear/Nose/Throat:

	YES	NO
Hearing Loss	___	___
Ringing in Ears	___	___
Sinus Infection	___	___
Nosebleeds	___	___
Sore Throat	___	___
Difficulty Swallowing	___	___
Bleeding Gums	___	___
Enlarged Glands	___	___
Loss of Taste	___	___

Respiratory:

	YES	NO
Asthma	___	___
Emphysema	___	___
Shortness of Breath	___	___
Cough/Wheezing	___	___
Sleep Apnea	___	___

Genitourinary:

	YES	NO
Kidney Disease	___	___
Kidney Stone	___	___
Pain/Burning Urination	___	___
Frequent Urination	___	___
Prostate Problems	___	___

Neurological:

	YES	NO
Stroke	___	___
Seizures	___	___
Dizziness	___	___
Head Injury	___	___
Numbness	___	___
Severe Headaches	___	___
Pinched Nerves	___	___
Parkinson's disease	___	___

Allergic/Immunologic:

	YES	NO
Hives	___	___
Allergy Shots	___	___
Steroid Shots	___	___
HIV/AIDS	___	___
Immune Disorder	___	___

Eyes:

	YES	NO
Glaucoma	___	___
Double Vision	___	___
Blurred Vision	___	___
Pain	___	___

Gastrointestinal:

	YES	NO
Poor Appetite	___	___
Nausea/Vomiting	___	___
Ulcers	___	___
Gallbladder Problems	___	___
Bowel Problems	___	___
Constipation	___	___
Diarrhea	___	___
Bloody Stools	___	___
Liver Problems	___	___

Skin:

	YES	NO
Skin Ulcers	___	___
Skin Disease	___	___
Eczema	___	___
Psoriasis	___	___
Rashes	___	___

Hematologic/Lymphatic:

	YES	NO
Cancer	___	___
Blood Clots	___	___
Hepatitis	___	___
Bruise Easily	___	___

Women Only:

	YES	NO
Are you pregnant	___	___
Lumps in Breasts	___	___
Dimpling in Breasts	___	___
Breast Pain	___	___
Irregular Menstruation	___	___
Painful Menstruation	___	___
Menopausal	___	___

Patient Health History

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name**_____**Suffix**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Social Security No. (Last four) _____**Home Phone** _____

Mobile Phone _____ **Work Phone**_____

Home email _____
*****Your e-mail address will not be used for Spam but will allow you access to an online portal to view your records and allow us to communicate to you personalized health information.***

Preferred Contact Method *(check one)*

❑ Home Phone ❑ Mobile Phone ❑ Work Phone

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Employer_____ **Occupation**_____

Employment Status ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Spouse's Name_____ **Spouse's Employer**_____

Emergency Contact Name & Number_____

Names and Ages of Your Children_____

How were you referred to our office? _____

Preferred Language ***(check one)***

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish	❑ Arabic
❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ I choose not to specify	

Verification Question ***(Choose <u>only one</u> question by checking the question, then give the answer to that question.)***

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
*******Answers must be at least 6 characters*******

Current medications including frequency and dosage, if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

Briefly list why you are here today: _____

_____

Date of Injury: _____ **Date Symptoms First Appeared:** _____

Have you ever had the same condition: ❑ **Yes** ❑ **No If yes, when?** _____

List other practitioners seen for this injury/condition: _____

Have you had chiropractic care? ❑ Yes ❑ No **Please describe:** _____

_____

What is the name of your family physician? _____

Has any doctor diagnosed you with Hypertension (High Blood Pressure)? ❑ Yes ❑ No If yes, describe:

_____

Has any doctor diagnosed you with Diabetes? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Have you had an X-ray, CT scan or MRI in the past six years? ❑ Yes ❑ No

If yes, where and when: _____

Have you ever had surgery or been hospitalized? List with dates*:* _____

_____

List any automobile accidents or injuries with dates: _____

_____

List any fractures or dislocations with dates: _____

Social History/Habits:

Sleep _____hours Coffee/Tea _____cups/day Alcohol _____drinks/week Soda _____drinks/day

Water _____glasses/day Exercise _____/week Recreational Drug Use: ____None ____Past ____Present

Physical Stress Level: _____Mild _____Moderate _____High

Emotional Stress Level: _____Mild _____Moderate _____High

Family History:

	Arthritis	Cancer	Diabetes	Heart disease	High blood pressure	Stroke	Psychiatric	Other
Father								
Mother								
Brothers								
Sisters								
Sons								
Daughters								

Recreational Activities:

_____backpacking _____biking _____bowling _____gardening _____golf _____racquetball _____running

_____tennis _____walking _____hunting _____fishing Other _____

INSURANCE

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

This Office is a participating provider with several insurance companies. For the companies that we do not participate with there may be out of network benefits that would cover all or part of your services. This Office will make every possible effort to verify your benefits prior to proceeding with any services. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Check type of Insurance coverage:

❑ Workman's Compensation ❑ Automobile Insurance Policy ❑Company Health Plan ❑ Group Policy

❑ Personal Policy ❑ Other

_____

Patient's Signature

Date: _____

_____

Guardian's Signature