CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Personal Information

Full Name ______________________________ Date ______________

Mailing address

____

Street City State Zip

Home Phone ( )_______________Work Phone ( )_______________

Cell Phone ( ) _______________Best time and place to contact you _______________

Email_______________________________________

Spouse/Guardian Name ______________________________________

Marital Status: M S W D Age ________ Birth date ________No. of children ________

Pregnant?______ Height _______ Weight _______ Occupation ______________________

Employer's Name and Address

____

Spouse Occupation/Employer

____

Name of person responsible for this account

____

WHO MAY WE THANK FOR REFERRING YOU?______________________________

Who may we contact in case of an emergency?
Name:______________________________ Phone:______________________

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 History"** section

I. HEALTH CONCERNS

List health concerns according to their severity	Rate of Severity 1=mild 10=worst imaginable	Date started & for how long?	If you had the condition before, when?	Did Problem begin with an injury?	% of time pain is present
1.________	______	______	______	______	______
2.________	______	______	______	______	______
3.________	______	______	______	______	______
4.________	______	______	______	______	______

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)

____
____
____

What activities aggravate your condition?

____
____
____

Other Doctor's seen for this condition:
"Limited Scope" Chiropractor (Focuses mainly on neck and back pain) ______
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns) ______
Medical Dr. ______ Dentist _______ Other ____________________

1. Name/Address: ____
   When: ____________________ What did they say was wrong? ______________________________
   What did they do? ____ Did it help? _________________

2. Name/Address: ____
   When: ____________________ What did they say was wrong? ______________________________
   What did they do? ____ Did it help? _________________

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

____
____
____

Is this condition interfering with your: work____ sleep____ daily routine____ sports/exercise____
Other ____

Are you unable to do certain activities that you would like to do because of this pain, illness, condition? (i.e. sports, walk, pick up grandchildren, etc.) If so, what?

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____
____
____

What lesson(s) have you taken home from your healing process to date?

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____
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GENERAL HEALTH HISTORY SECTION

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 _______________________

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type____When_________________ Hospitalized _____Yes _____No
2. Type____When_________________ Hospitalized _____Yes _____No
3. Type____When_________________ Hospitalized _____Yes _____No

Have you ever had x-rays taken? ________

Area(s) of body:____

When?______________________Where(city/town and state)?____

Do you wear orthotics or heel lifts? Yes_____ No______

CURRENT MEDICINE(S)/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 __________

PAST HEALTH HISTORY:

Mark the following conditions you may have had or have now (- have had +have now)

___ Allergy ___Diarrhea ___Measles ___Rheumatic Fever ___Alcoholism ___Eczema
___Miscarriage ___Stroke ___Anemia ___Multiple Sclerosis ___HIV (Aids) ___Gout
___Arteriosclerosis ___Emphysema ___Mumps ___Sinus Problems ___Arthritis ___Neuritis
___High Blood Pressure___Asthma ___Nervousness ___Thyroid Problems ___Ulcers ___Cancer
___Heart Disease ___Depression ___Convulsions___Venereal Disease ___Malaria ___Pleurisy
___Constipation ___Pneumonia ___Cold Sores ___Whooping Cough ___Polio ___Neck Pain
___Migraines ___Headaches ___Menstrual Cramps ___Back Pain ___Epilepsy___Gall Bladder Problems
___Irregular Periods ___Diabetes ___Tuberculosis___Heart Attack___Low Blood Sugar___Ringing in ears
___Other (please explain)

____

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____

____

____

____

Please list your top three stresses 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 stress (work, relationships, finances, self-esteem, etc.)
   a. ______________________________
   b. ______________________________
   c. ______________________________

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 us to better understand you which was not covered on this form?

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Why are you here at this point in time?

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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 ______________________________