CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential.
We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Have you consulted a chiropractor before?
☐ No ☐ Yes When? _____

If so, whom?

Your Last Name

Gender
☐ Male ☐ Female

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Address

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

Address

May we contact you at work?
☐ Yes ☐ No

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name

First Name | Middle Name (or Initial)

Who carries this policy?
☐ Self ☐ Spouse ☐ Parent

Insured's Employer

Address

State/Province | ZIP/Postal Code | Employer's Phone

1. **The symptom(s) that have prompted me to seek care today include:** _____

_____

2. **And the results of :** ☐ An accident or injury
   ☐ Work ☐ Auto ☐ Other _____
   ☐ A worsening long-term problem
   ☐ An interest in: ☐ Wellness ☐ Other_____

3. **Onset** (When did you first notice your current symptoms?)

   _____/_____/_____

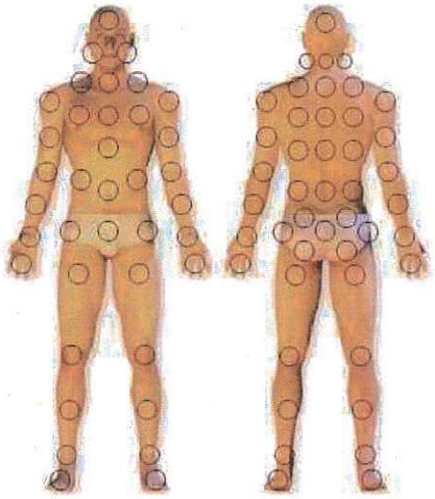
4. **Intensity** (How extreme are your current symptoms?)

   0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10
   Absent Uncomfortable Agonizing

5. **Duration and Timing** (How often do you feel it?)
   ☐ Constantly (76-100%)
   ☐ Frequently (51-75%)
   ☐ Occasionally (26-50%)
   ☐ Intermittently (0-25%)

6. **Quality of Symptoms** (What does it feel like?)
   ☐ Numbness
   ☐ Tingling
   ☐ Stiffness
   ☐ Dull
   ☐ Aching
   ☐ Cramps
   ☐ Nagging
   ☐ Sharp
   ☐ Burning
   ☐ Shooting
   ☐ Throbbing
   ☐ Stabbing
   ☐ Other
   _____

7. **Location** (Where does it hurt?) Mark the area(s) on the illustration.



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

   _____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc?)

   What tends to worsen the problem?

   _____

   What tends to lessen the problem?

   _____

10. **Prior Interventions** (What have you done to relieve the symptoms?)
    ☐ Prescription Medication ☐ Surgery ☐ Ice
    ☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat
    ☐ Homeopathic remedies ☐ Chiropractic
    ☐ Physical Therapy ☐ Massage
    ☐ Other _____

11. **Have you traveled internationally in the last 6 months? ☐ Yes ☐ No If yes, where?** _____

12. **What else should the doctor know about your current condition?** _____

_____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire your body. Please mark the box beside any conditions that you **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	Back Problems	☐	☐	Hip disorders
☐	☐	Knee injuries	☐	☐	Foot/ ankle pain	☐	☐	Shoulder Problems	☐	☐	Elbow/ wrist pain	☐	☐	TMJ Issues	☐	☐	Poor posture

☐ **NONE** **Initials** _____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & needles	☐	☐	Numbness

☐ **NONE** **Initials** _____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High blood pressure	☐	☐	Low blood pressure	☐	☐	High cholesterol	☐	☐	Poor circulation	☐	☐	Angina	☐	☐	Excessive bruising

☐ **NONE** **Initials** _____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Shortness of breath	☐	☐	Hay fever	☐	☐	Emphysema	☐	☐	Pneumonia

☐ **NONE** **Initials** _____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Ulcer	☐	☐	Anorexia/ Bulimia	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

☐ **NONE** **Initials** _____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred vision	☐	☐	Ringing in ears	☐	☐	Chronic ear infection	☐	☐	Hearing loss	☐	☐	Loss of smell	☐	☐	Loss of taste

☐ **NONE** **Initials** _____

Patient Name _____

Doctor's Initials _____

Patient Name

g. Integumemtary

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Skin cancer	☐	☐Psoriasis	☐	☐Eczema	☐	☐Acne	☐	☐Hair loss	☐	☐Rash

☐ NONE Initials _____

h. Endocrine

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Thyroid issues	☐	☐Immune disorder	☐	☐Frequent urination	☐	☐Hypoglycemia	☐	☐Swollen glands	☐	☐Low energy

☐ NONE Initials _____

i. Genitourinary

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Kidney stones	☐	☐Infertility	☐	☐Erectile dysfunction	☐	☐Prostate issues	☐	☐Bedwetting	☐	☐PMS symptoms

☐ NONE Initials _____

j. Constitutional

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Fainting	☐	☐Low libido	☐	☐Sudden weight change	☐	☐Fatigue	☐	☐Poor appetite	☐	☐Weakness

☐ NONE Initials _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past of **Have** now.

Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Tuberculosis
☐	☐	Alcoholism	☐	☐	Typhoid fever
☐	☐	Arteriosclerosis	☐	☐	Ulcer
☐	☐	Cancer	☐	☐	Allergies
☐	☐	Chicken Pox			Food: _____
☐	☐	Diabetes			Medications: _____
☐	☐	Epilepsy			_____
☐	☐	Glaucoma			Environmental: _____
☐	☐	Goiter	☐	☐	Other: _____
☐	☐	Gout			_____
☐	☐	Heart disease			_____
☐	☐	Hepatitis			_____
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			
☐	☐	Polio			
☐	☐	Rheumatic Fever			
☐	☐	Scarlet Fever			
☐	☐	Sexually transmitted disease			
☐	☐	Stroke			

15. Operations

Surgical interventions which may or may not have included hospitalizations.

	Date
☐ Appendix Removal	___/___/____
☐ Bypass surgery	___/___/____
☐ Cancer	___/___/____
☐ Cosmetic Surgery	___/___/____
☐ Elective Surgery: _____	___/___/____
☐ Eye Surgery	___/___/____
☐ Hysterectomy	___/___/____
☐ Pacemaker	___/___/____
☐ Spine: _____	___/___/____
☐ Tonsillectomy	___/___/____
☐ Vasectomy	___/___/____
☐ Other: _____ _____	___/___/____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently.**

Past	Currently	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Blood transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacement
☐	☐	Inhaler
☐	☐	Massage therapy
☐	☐	Physical therapy
☐	☐	Nutritional supplements:

List _____

_____

_____

☐ ☐ Medications (Prescriptions & Over the Counter)

_____

_____

_____

_____

_____

_____

17. Injuries

Have your ever....

- ☐ Had a fractured or broken bone
  If so, where_____
  when ___/___/____
- ☐ Had spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Been injured in an accident
  If so, when ___/___/____
- ☐ Used a crutch of other support
- ☐ Used neck or back bracing
- ☐ Received a tattoo
- ☐ Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell the doctor about the health of your **immediate** family members, e.g. mother, father, sister, brother.

☐ Alzheimer's	☐ Cancer	☐ Diabetes	☐ Hypertension	☐ Thyroid disorder
☐ Arthritis	☐ Depression	☐ Heart disease	☐ Stroke	☐ Other _____

19. Are there any other hereditary health issues that you know about? _____

_____

SOCIAL

20. Social History

Tell the doctor about your health habits and stress levels.

Alcohol use	☐ Daily	☐ Weekly	☐ Never	How much? _____	Prayer or meditation?	☐ Yes	☐ No
Coffee use	☐ Daily	☐ Weekly	☐ Never	How much? _____	Job pressure/stress?	☐ Yes	☐ No
Tobacco use	☐ Daily	☐ Weekly	☐ Never	How much? _____	Financial peace?	☐ Yes	☐ No
Exercising	☐ Daily	☐ Weekly	☐ Never	How much? _____	Vaccinated?	☐ Yes	☐ No
Pain Relievers	☐ Daily	☐ Weekly	☐ Never	How much? _____	Mercury fillings?	☐ Yes	☐ No
Soft drinks	☐ Daily	☐ Weekly	☐ Never	How much? _____	Recreation drugs?	☐ Yes	☐ No
Water intake	☐ Daily	☐ Weekly	☐ Never	How much? _____			

Hobbies:_____

Doctor's Initials

21. Activities of Daily Living

How does this condition interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	☐	☐	☐	☐	Grocery shopping	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	Showering or bathing	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Love life	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐	Getting to sleep	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	Staying asleep	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	Concentrating	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐	Yardwork	☐	☐	☐	☐

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? ____ Hours

24. What is the **type** and **approximate age** of your mattress and pillow?

_____

25. What is your preferred sleeping position?

_____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

_____ Initials **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____ Initials **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

_____ Initials **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of late menstrual period (MM/DD/YYYY): _____**

_____ Initials **I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care of this office.**

_____ Initials **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any non-covered services I receive.**

_____ Initials **To best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity of cause of my health concern.**

If patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

_____ Patient Name

_____ Doctor's Initials