

PATIENT INFORMATION & HEALTH HISTORY

Name: _____	How would you like to be addressed _____
Date of Birth ____ - ____ - _____	Age ____ Marital Status: _____ Spouse Name _____
Address: _____	City _____ State _____ Zip _____
Your Occupation: _____	Employer: _____
Best Contact # (____) _____ - _____	Alternate Contact # (____) _____ - _____ E-MAIL _____

About the Insured (Policy Holder - IF OTHER THAN PATIENT) – please give the receptionist your insurance card for verification	
Name: _____	Relation to Patient: _____ Date of Birth ____ - ____ - _____
Address: _____	City _____ State _____ Zip _____
Phone #: (____) _____ - _____	Employer: _____ Do you have Supplemental Insurance? Y / N

1. WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? (Most new patients come from a direct patient referral) _____

 2. WHAT DID THEY SAY THAT MADE YOU CONTACT US? _____
 - a. *IF NOT REFERRED* – How did you hear about our office? _____

 3. HAVE YOU EVER BEEN TO A CHIROPRACTOR? YES / NO
 - a. CHIROPRACTOR / OFFICE NAME _____
 - i. Phone # _____ Fax # _____
 - b. HOW LONG WERE YOU UNDER CARE? _____ # OF VISITS _____
 - c. DATE OF LAST VISIT WAS? _____
 - d. WHAT DID YOU LIKE ABOUT YOUR EXPERIENCE: _____
 - e. WHAT DID YOU DISLIKE ABOUT YOUR EXPERIENCE: _____
 - f. WHAT TYPE OF ADJUSTMENTS DID YOU RECEIVE - Manual/Hand Drop Table Instrument
 - g. WHAT TYPE OF ADJUSTMENTS DID YOU PREFER - Manual/Hand Drop Table Instrument
-
4. LAST TIME YOU HAD SPINAL X-RAYS? _____
-
5. WHAT DO YOU THINK IS THE CAUSE OF YOUR PAIN? _____
-
6. WHAT HAVE YOU HEARD ABOUT CHIROPRACTIC CARE THAT MAKES YOU BELIEVE WE MAY HELP YOU? _____
-
7. WHAT ARE YOUR SPECIFIC GOALS FOR CARE IN THIS OFFICE?
 - a. Short Term _____
 - b. Long Term _____
-
8. WHAT IS THE MOST IMPORTANT THING FOR YOU TO BE ABLE TO DO WHEN YOU ARE BETTER? _____
-
9. IF WE FIND A STRUCTURAL CAUSE TO YOUR PROBLEM WHAT TYPE OF CARE DO YOU DESIRE?
Pain Relief (Temporary) / Structural Correction (Long Term Stability) / Doctor Decide
-
10. DESCRIBE ANY LIFESTYLE CHANGES THAT YOU THINK WILL HELP YOU ACHIEVE THESE GOALS _____
-
11. WOULD YOU BE INTERESTED IN ATTENDING AN ESSENTIALS of HEALTH WORKSHOP YES / NO
Topics Include: The Basics of Health, Maximized Muscle – Max T3 Exercise, Power Nutrition

Patient Name: _____

Date: _____

HISTORY of PRESENT ILLNESS (*Why you are here today*)

MAIN COMPLAINT (CIRCLE ONLY ONE):

a) Neck Pain b) Mid-Back Pain c) Lower Back Pain d) Arm Pain L/R e) Leg Pain L/R f) Headache/Jaw Pain g) Other

CHARACTER (Describe the pain): Dull Ache Sharp/Stabbing Throb Burning Other: _____

SEVERITY - RATE PAIN (0= none -----10= unbearable) @ Best___/10 Average___/10 @ Worst___/10

a) Mild Annoyance (NO impairment) b) Slight (Mild Impairment) c) Moderate (marked impairment) d) Severe (bed ridden)

DURATION: a) Intermittent (25% of the time) b) Occasional (25-50%) c) Frequent (50-75%) d) Constant (76-100%)

HOW DOES THIS MAKE YOU FEEL? Angry Anxious Stressed Irritable Moody Other: _____

DATE of ONSET: _____ **MODE OF ONSET:** a) Overexertion/Strenuous Position b) Fall/Trip/Slip

c) Chronic/Recurring d) Auto Accident/Work Related Accident (**SEE FRONT DESK**) e) Unknown

RELIEVING FACTORS: a) Rest/Exercise b) Bracing/Taping c) Sitting/Standing/Lying d) Hot/Cold Packs e) other: _____

AGGREGVATING FACTORS: a) Cough/Sneeze b) Lifting/Bending/Push/Pull c) Driving/Riding/Sitting d) other: _____

SINCE THIS EPISODE BEGAN IS THE PAIN: IMPROVING SAME WORSE

PAIN RADIATES: Y / N Radiates where: _____

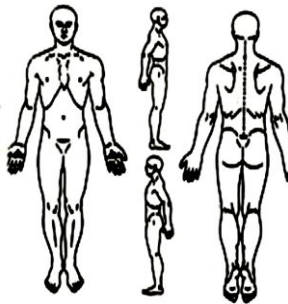
TREATMENT: _____ Did it help? Y / N

HAVE YOU EVER HAD THIS CONSITION BEFORE? Y / N 1-2X 3-4X 5+ Last Episode: _____

WHAT ACTIVITIES ARE YOU UNABLE TO PERFORM DUE TO PAIN? (circle) - walking / driving / sitting / standing / lifting / reading / personal care sleep / recreation / social life / play w/ kids / work (dates off ____ to ____)

WHAT ACTIVITIES ARE YOU PERFORMING IN PAIN? (circle) - walking / driving / sitting / standing / lifting / reading / personal care sleep / recreation / social life / play w/ kids / work (dates off ____ to ____)

MARK THE AREA OF PAIN ON THE DIAGRAM using B=Burning, A=Ache, N=Numb, T=Tingle, P=pain



HEALTH HABITS / SOCIAL HISTORY

Stress Level (circle): Low Moderate High **Sleep Position (circle):** Stomach Side Back # pillows used _____

Exercise: Y / N _____x Week **Water** _____ oz / day **Alcohol** Y / N _____ / week **Caffeine Products** Y / N _____/day

Smoking (circle) YES / NO / QUIT How Much _____ / day Quit When _____ **Exposure to Second Hand Smoke** YES / NO

Recreational Drugs? YES / NO

Work Duties Include (check): ___Sitting ___Standing ___Computers ___Bending ___Heavy Lifting ___Overhead Reaching

Other: _____ **Job Satisfaction:** High Average Low

DOCTORS NOTES: _____

REVIEW OF SYSTEMS

(mark those symptoms that you have **NOW < 3 months** or **PAST > 3 months**, NEVER- Leave BLANK)

Dr/ Staff Notes

GENERAL: Unexplained Weight Loss Unexplained Weight Gain Fatigue Allergies General Pain	Now / Past Now / Past Now / Past Now / Past Now / Past	CARDIAC: Pain in Chest Palpitations High Blood Pressure Low Blood Pressure Rapid Heart Rate	Now / Past Now / Past Now / Past Now / Past Now / Past	MUSCULOSKELETAL Neck Pain Neck Stiffness Swollen Neck Glands Upper Back Pain Middle Back Pain Low Back Pain Low Back Stiffness Back Muscle Spasm Arm / Hand Pain Leg / Feet Pain Joint Pain / Swelling	Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past	
HEAD / FACE: Headache Migraine Sinus Pain	Now / Past Now / Past Now / Past	LUNG: Cough Chest Congestion Shortness of Breath Wheezing Asthma	Now / Past Now / Past Now / Past Now / Past Now / Past	NERVE Dizziness or Vertigo Lightheaded Weakness in arms/legs Tingling Numbness Increased Sensitivity touch Seizure / Tremors	Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past	
EYES: Vision / eyesight problems Sensitive to light Eye Pain	Now / Past Now / Past Now / Past	GASTROINTESTINAL Appetite Changes Heartburn Nausea Vomiting Diarrhea Constipation	Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past	RED FLAGS (Sudden Onset) * Numbness both arms/legs * Seat / Rectal Numbness * Loss of Bowel /Bladder Control Sexual Dysfunction	Now / Past Now / Past Now / Past Now / Past	
EAR, NOSE, MOUTH, THROAT: Recurring Earache Recurring Ear Infection Hearing Loss Ringing in Ear Nasal Congestion Jaw Pain / Click / Lock Bleeding Gums	Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past Now / Past	GENITOURINARY: Painful Urine Urinary Tract Infection Difficult Urination Increased Frequency	Now / Past Now / Past Now / Past Now / Past	PHYSCHOLOGIC Mood / Energy Changes Sleep Disturbances Anxiety / Depression	Now / Past Now / Past Now / Past	
ENDOCRINE: Excessive Thirst Excessive Sweating Night Sweats Hormonal Imbalance	Now / Past Now / Past Now / Past Now / Past	GYNECOLOGIC: Heavy Menses Irregular Cycle Pregnancy Difficulty	Now / Past Now / Past Now / Past			
		PREGNANT LAST PERIOD DATE	Y / N _____			

MEDICATION: List all the medication including over the counter & supplements that you currently take and who prescribed (List is OK)

MEDICATIONS (Rx or OTC)	RX BY DR / SELF	SUPPLEMENTS	RX BY DR / SELF
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY - List all Medical Conditions / Surgeries / Hospitalizations you have had (A written list is ok if available)

CONDITION / SURGERY	YEAR	CONDITION / SURGERY	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TRAUMA HISTORY (ALL ACCIDENTS ARE IMPORTANT) – even if minor & you did not receive any form of treatment

Motor Vehicle Accidents: How Many # _____ / Years: _____
 Treatment: _____
 Sports Played: _____ Major Injuries: _____
 Other Injury (Work / Home): _____

FAMILY HISTORY: list any health problems in your family. Use icons to indicate (**M-mother, F-father, S-Sibling, C-Children**)

Cancer _____ Diabetes _____ Heart Disease _____ Back Problems _____
 Deceased / Cause of Death _____

To the best of my knowledge, the information provided is accurate and correct. I authorize the doctor to perform an examination (including x-rays & diagnostics, if needed) of myself or my minor child for treatment purposes and I further authorize the doctor to contact my family physicians to discuss my treatment and any pertinent health history. **I authorize assignment of my insurance rights and benefits, directly to the provider for services rendered.**

Patient Signature

Parent / Guardian Signature (minors)

Date

DOCTORS NOTES: _____

Complicating Factors: 1) Abnormal illness behavior; 2) Job dissatisfaction; 3) Past Hx of >4 episodes; 4) Symptoms > 1 wk; 5) Severe pain intensity (VAS >7); 6) New condition / injury related to pre-existing structural pathology or skeletal anomaly

Dr Signature (after reviewing with patient) _____

Date: _____