

PERSONAL HISTORY

Date: _____ Case Number _____
Name: _____ Address _____
City: _____ State: _____ Zip _____
Home Phone: _____ Business Phone: _____
Birth Date _____ Age: _____ Sex: M F Height: _____ Weight: _____
Business/Employer: _____ Type of Work: _____
Check One: Married Single Widowed Divorced Separated
SS # _____ Spouse's SS # _____ No. of Children _____
Referred To This Office By: _____
Who Is Responsible For Your Bill, You and: Spouse Workman's Compensation Medicare
 Auto Insurance Personal Health Insurance Other _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____
Major Complaint: _____
Other Doctor's Seen For This Condition: _____
When Did This Condition Begin: _____
Are There Others In Your Family With This Same Condition: _____
If Disabled From Work Please Give Dates: _____
 Job Related Auto Related Date of Accident/Injury _____
Medication You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure
 Insulin Aspirin/Similar Other _____

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: Appendix Tonsils Gall Bladder Hernia Heart Back
 Neck Leg Other _____

Major Accidents or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: Doctor's Name and Approximate Date of Last Visit: _____

Have You Been Treated For Any Health Condition In The Last Year? Yes No

If Yes, Please Explain: _____

Does Anyone Else In Your Family Have The Same Or Similar Condition? _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

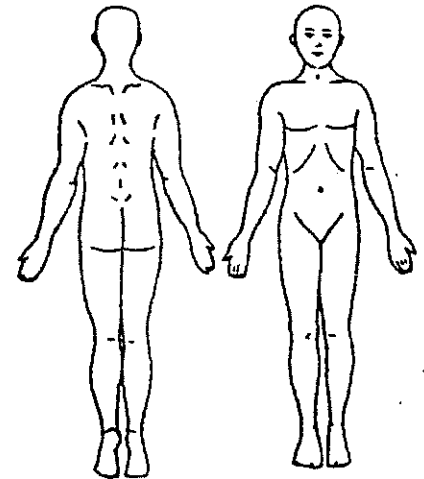
- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction

FEMALES ONLY:

When was your last period? _____

Are you Pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort.

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

Why Chiropractic? People go to the Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic (**Preventive Care**). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his prepared recommendation is an incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care Corrective Care Preventive Care Check here if you want the doctor to select the type of care appropriate for your condition.

_____ Date

_____ Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

**THE PURPOSE OF
OUR CHIROPRACTIC OFFICE
IS TO SUPPORT
EACH INDIVIDUAL
IN ACHIEVING THEIR
OPTIMUM HEALTH
AND TO
EDUCATE THEM
SO THAT THEY MAY
UNDERSTAND HEALTH
AND CHIROPRACTIC
AND IN TURN EDUCATE
OTHERS.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature X _____ SS # _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____