

# Patient History

## Patient Data

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_ Sex \_\_\_\_\_ M \_\_\_\_\_ F  
Address \_\_\_\_\_ Apt./Unit \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ ext \_\_\_\_\_ (C) \_\_\_\_\_  
Email Address \_\_\_\_\_ @ \_\_\_\_\_ (office use only)  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Status: \_\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed  
Name of Spouse \_\_\_\_\_ Employer \_\_\_\_\_  
Phone (W) \_\_\_\_\_ ext \_\_\_\_\_ (C) \_\_\_\_\_  
Referred to the office by \_\_\_\_\_  
Emergency contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## Insurance Information

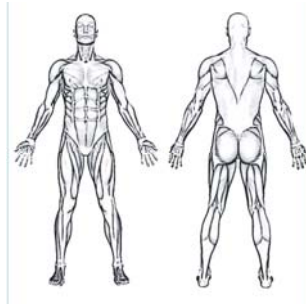
Who is responsible for your bill, You and \_\_\_\_\_ Spouse \_\_\_\_\_ Worker's Comp \_\_\_\_\_ Auto Insurance \_\_\_\_\_ Medicare \_\_\_\_\_  
Personal Health Insurance (Name) \_\_\_\_\_ ID no. \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Flex Plan available \_\_\_\_\_ Yes \_\_\_\_\_ No

## What Brings You to our Office

\_\_\_\_\_ Emergency \_\_\_\_\_ New Injury \_\_\_\_\_ Old Injury \_\_\_\_\_ Chronic Pain \_\_\_\_\_ Wellness Visit  
Nature of injury/condition \_\_\_\_\_ Automobile \_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Other \_\_\_\_\_  
Date of accident \_\_\_\_\_ Describe \_\_\_\_\_  
What is your major complaint \_\_\_\_\_  
Other complaints \_\_\_\_\_  
Date symptoms first appeared \_\_\_\_\_ Did it begin: \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time  
Type of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burning \_\_\_\_\_ Throbbing  
Does the pain radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate  
Do you experience numbness or tingling \_\_\_\_\_ Yes \_\_\_\_\_ No  
Is the pain getting worse? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ comes and goes  
What makes the symptoms increase? \_\_\_\_\_  
What relieves the symptoms? \_\_\_\_\_  
Do you experience pain daily? \_\_\_\_\_ Do changes in the weather affect your symptoms? \_\_\_\_\_  
Does your condition interfere with your \_\_\_\_\_ work \_\_\_\_\_ sleep \_\_\_\_\_ daily routine  
Has this or something similar happened in the past? \_\_\_\_\_ yes \_\_\_\_\_ no Explain \_\_\_\_\_  
Have you been treated by a medical physician for this pain? \_\_\_\_\_ yes \_\_\_\_\_ no Where \_\_\_\_\_  
Have you been treated by a chiropractor? \_\_\_\_\_ yes \_\_\_\_\_ no Dr.'s name & no. \_\_\_\_\_

**Rate your Pain** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Using the adjacent body chart shade in the affected areas



People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief of care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

**Relief Care**

Relief care is that care necessary to get rid of your Symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, But not fixing the leak.

**Corrective Care**

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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

Relief Care     Corrective Care     Doctor to select the type of care appropriate for your condition

**Medical History**

Have you been treated for any conditions in the last year?  yes  no Describe \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Are you taking birth control?  yes  no      Are you nursing?  yes  no

Are you pregnant?  yes  no      How many weeks? \_\_\_\_\_

What medications, vitamins, minerals, or herbs do you currently take are you taking and for what conditions ( list dosage and amounts)? \_\_\_\_\_

Have you ever been in an auto accident?  yes  no If yes, explain when and how? \_\_\_\_\_

Have you ever had surgery?  yes  no Explain \_\_\_\_\_

Do you have or have had any of the following diseases, medical conditions or procedures?

Heart attack	Y	N	Heart/surgery pacemaker	Y	N	Heart murmur	Y	N
Congenital heart defect			Mitral valve prolapse			Artificial valves		
Alcohol/drug abuse			Venereal disease			Hepatitis		
Anemia/diabetes			Shingles			Cancer		
Frequent neck pain			Glaucoma			Kidney problems		
High/low pressure			Psychiatric problems			Rheumatic fever		
Sever/frequent headaches			Tuberculosis			Ulcers/colitis		
Fainting/seizures/epilepsy			Sinus problems			Emphysema/asthma		
Arthritis			Difficulty breathing			Chemotherapy		
Lower back problems			Art. bones/joints/implants					

**Family History    Family member    Present and past health conditions (Ex: heart disease, cancer, diabetes, arthritis, etc.)**

_____	_____
_____	_____
_____	_____

We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_

Date \_\_\_\_\_