PATIENT HISTORY

Date_____________________________

Name ____ Birth Date _________________ Age _________ Male Female

Address____ City______________________ State_________ Zip_________________

Phone (hm) _____________________________ Work_____________________________ Cell / Pager ______________________________

E-Mail _____________________________________ How were you referred to our office? ____

Your e-mail address will not be shared with third parties and will only be used to communicate important information about your health.

Occupation __________________________ Employed by _______________________

Work Address ____ City, State, Zip ____

Married Single Divorced Widowed Separated Names & Ages of Children ___________________________________

Spouse's Name (or parent) ________________________________ Spouse's Employer ____

Have you ever had Chiropractic Care before? ___________ If yes, when? ____

List your chief complaints in order of severity:

1. ____ For how long?____
2. ____ For how long?____
3. ____ For how long?____

List other Doctors consulted for this condition:

1. ____ Address ____
2. ____ Address ____

Is this related to a recent work injury or illness? _________ Have you reported it to your employer?____________________________

Is this injury or illness related to a recent automobile accident? ________ If YES, what state did it occur? ______ And name of

YOUR: Auto Insurance Co. ____ Policy # _____________________________________

Claim # ____ Phone # ____

Is this injury or illness related to an non-work or non-auto related accident? _________

Date and details:____

Do you have any type of MEDICARE Health Insurance? ________ **If yes, present your card(s) to receptionist.**

If you have MEDICARE
Complete the following information if your spouse is the policyholder and carries at least one of the insurance policies.

Spouse's Name _________________________________ Spouse's SS # ____________________________ DOB _____________________

Company ____ Policy # ____

Company ____ Policy # ____

Are you or your spouse retired, if yes, date of retirement: Yourself _____________________ Spouse ________________________________

Method of Payment you plan to use for today's charges: Check Cash MasterCard VISA Discover

Notice: Exam and x-rays are necessary to determine or verify a diagnosis, type and length of care, and the exact nature of spinal subluxation. The following office policy prevails:

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for x-rays is for analysis only. The film itself is part of your permanent record and cannot be released**

Patient's Signature

____

PATIENT HISTORY continued

Name ____ Date ___________________

Have you been treated for any conditions in the last year? ________

If yes, please describe ____

Date of last physical exam _________________ Is there a chance that you are pregnant? _________

Have you had X-rays taken? _________ If yes, where? ____

What medications are you taking and for what conditions (Please list dosage and amounts, etc).

____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

____

Have you ever	yes	no	Briefly explain
Broken bones?			____
Been hospitalized?			____
Been in an auto accident?			____
Had sprains/strains?			____
Been struck unconscious?			____
Had surgery?			____

Habits	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft drinks				
Water				
Salty foods				
Sugary foods				
Artificial sweeteners				

	yes	no
Do you experience pain every day?		
Do your symptoms interfere with daily life?		
Does pain wake you up at night?		
Are your symptoms worse during certain times of the day?		
Do changes in weather affect your symptoms?		
Do you wear orthotics?		

What activities aggravate your symptoms?

____

____

____

____

Have you ever suffered from

Alcoholism	Chest Pain/Conditions	Frequent Urination	Loss of taste	Tuberculosis
Allergies	Cold extremities	Headache	Neck Pain or Stiffness	Ulcers
Anemia	Constipation Cramps	Hemorrhoids	Nervousness	Varicose Veins
Arteriosclerosis	Depression	High Blood Pressure	Nosebleeds	Venereal Disease
Arthritis	Diabetes	Hot Flashes	Pacemaker	Other:
Asthma	Digestion Problems	Irregular Heart Beat	Polio	______________
Back Pain	Dizziness	Irregular Cycle	Poor Posture	______________
Breast lump	Ears Ring	Kidney Infection	Prostate Trouble	______________
Bronchitis	Excessive Menstruation	Kidney Stones	Sciatica	______________
Bruise Easily	Eye Pain/Difficulties	Loss of memory	Shortness of breath	
		Loss of balance	Swollen Joints	