CONFIDENTIAL
HEALTH INFORMATION

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

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ◯ No ◯ Yes **When?** ________ **If so, whom?** ________

Whom may we thank for referring you?

Your Last Name | **Birth Date (MM/DD/YYYY)** | **Age**

Your First Name | **Your Middle Name (or Initial)** | **Gender** ◯ Male ◯ Female | **Nickname**

Address of Permanent Residence

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated | **Ethnicity**

City | **State/Province** | **ZIP/Postal Code**

Seasonal Address | **Spouse's Name**

City | **State/Province** | **ZIP/Postal Code** | **Children's names and Ages**

Home Phone | **Cell Phone**

Are you Medicare eligible? ☐ Yes ☐ No

If Yes, please present your Medicare card at the front desk, and please read our Special Notice to Medicare Patients. (Medicare replacement policies are not the same as Medicare)

Email Address

Emergency Contact | **Emergency Contact's Phone**

Your Occupation

Your Employer | **Work Phone**

Address

May we contact you at work? ◯ Yes ◯ No

City | **State/Province** | **ZIP/Postal Code**

Preferred method of contact? ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Primary Care Provider's Name

Request for Confidential Communication and Use of Email

Our office uses text messaging, as well as email to contact our patients regarding care, appointment reminders, holiday closures, or other announcements pertinent to our office.

Please read and complete the required areas to the right advising how you would prefer we disclose detailed and/or potentially sensitive information to you in the event we must contact you.

You may..

contact me via home and/or cell phone	☐ Yes	No
leave a detailed message on my home answering	Yes	No
machine leave a detailed message on my cell phone	Yes	No
contact me via text message	Yes	No
mail correspondence to my home address	Yes	No
leave a detailed message with someone I trust	Yes	No

If yes, who: ________ Relationship: ________ Phone #: ________

CONFIDENTIAL HEALTH INFORMATION

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

____

2. And are the result of (darken circle): ◯ 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

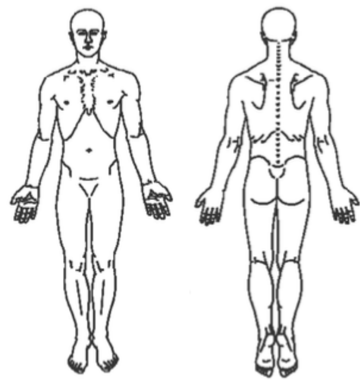
5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? ____________________

____

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?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



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	Other ________
◯ Physical therapy	◯ Massage	________

11. What else should we know about your current condition? ____________________

____

12. How does your current condition interfere with your:

Work or career: ____________________

Recreational activities: ____________________

Household responsibilities: ____________________

Personal relationships: ____________________

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	NONE ◯
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	NONE ◯ Initials ____

c. Cardiovascular

Had	Have		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		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	NONE ◯ Initials ____

(Continued from previous page)

h. Endocrine

Had	Have	Condition
○	○	Thyroid issues
○	○	Immune disorders
○	○	Hypoglycemia
○	○	Frequent infection
○	○	Swollen glands
○	○	Low energy

NONE ○ Initials ____

i. Genitourinary

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

NONE ○ Initials ____

j. Constitutional

Had	Have	Condition
○	○	Fainting
○	○	Low libido
○	○	Poor appetite
○	○	Fatigue
○	○	Sudden weight gain/loss (circle one)
○	○	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 or **Have** now.

Had	Have	Illness
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other: ________________

____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ 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	Treatment
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): ________________

____

____

____

____

____

____

17. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ________________

____

____

____

____

____

18. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

19. Family History

Some health issues are hereditary. Tell us about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	______	○	○	______	______	○	○
Father	______	○	○	______	______	○	○
Sister 1	______	○	○	______	______	○	○
Sister 2	______	○	○	______	______	○	○
Brother 1	______	○	○	______	______	○	○
Brother 2	______	○	○	______	______	○	○
______	______	○	○	______	______	○	○

20. Are there any other hereditary health issues that you know about? ________________

____

21. Social History

Tell us about your health habits and stress levels.

SOCIAL

Habit	Daily	Weekly	How much?
Alcohol use	○	○	________
Coffee use	○	○	________
Tobacco use	○	○	________
Exercising	○	○	________
Pain relievers	○	○	________
Soft drinks	○	○	________
Water intake	○	○	________

Question	Yes	No
Prayer or meditation?	○	○
Job pressure/stress?	○	○
Financial peace?	○	○
Vaccinated?	○	○
Mercury fillings?	○	○
Recreational drugs?	○	○

Hobbies: ________________________

22. Activities of Daily Living

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

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

23. What is the major stressor in your life? ______________________

24. How much sleep do you average per night? _______ **Hours**

25. What is the type and approximate age of your mattress and pillow? ______________________

26. What is your preferred sleeping position? ____________

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

28. What would be the most significant thing that you could do to improve your health? ______________________

____

29. 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 a 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 last menstrual period (MM/DD/YYYY):** ______________________

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

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

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

______________________________ Signature

______________________________ Date (MM/DD/YYYY)