

## CONFIDENTIAL PATIENT INFORMATION

### Personal Information

<b>Full name:</b>		<b>Date:</b>	
<b>Address:</b>			
Street	City	State	Zip
<b>Home phone:</b>		<b>Work phone:</b>	
<b>Cell phone:</b>		<b>Email address:</b>	
<b>Best time/place to contact you:</b>			
<b>Date of birth:</b>		<b>Age:</b>	
<b>No. of children:</b>		<b>Pregnant?    Yes <input type="checkbox"/>    No <input type="checkbox"/></b>	
<b>Social Security number:</b>			
<b>Occupation:</b>			
<b>Employer's name &amp; address:</b>			
<b>Marital status:    M    S    W    D</b>		<b>Spouse/guardian name:</b>	
<b>Spouse's Occupation/Employer:</b>			
<b>Name of person responsible for account:</b>			
<b>Name of Insurance Company and policy number:</b>			

**Who may we thank for referring you?** \_\_\_\_\_

### Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".*

### Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

\_\_\_\_\_

Since the problem started is it: About the same?       Getting better?       Getting worse?

What helps your condition? (for example – ice, heat, rest, stretching, etc.)

\_\_\_\_\_

Which activities aggravate your condition? \_\_\_\_\_

\_\_\_\_\_

Who have you seen for your condition?:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them and what did they do?	

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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## General Health History

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes  No

## Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

## Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) \_\_\_\_\_

## Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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## Do you:

Drink water?

Yes No How much? \_\_\_\_\_

Exercise?

Yes No How often? \_\_\_\_\_

Drink Soda?

Yes No (Diet or Regular)

What do you do for stress relief?

Please mark an "X" where you believe your health is and an "O" where you would like to be.

### NeuroSpinal Function Index (NSFi)



Is there anything else you would like to add that has not been discussed?

I consent to a professional and complete chiropractic examination, and chiropractic adjustment, if indicated.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

I understand that the doctor of chiropractic will provide a treatment plan tailored for my specific case and that it is my responsibility to be compliant in order to benefit the most from care.

Print Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_