Confidential Patient Care History

Please complete this questionnaire. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily to the treatment, we will not accept your case. – Thank You

Patient Information Date: _____

Patient Name:_____ Age: _____
Last First M.I.

Address: _____Sex: [ ] Male [ ] Female

_____D.O.B _____
City State Zip code

Whom may we thank for referring you? _____

Patient Social Security #: _____Patient Driver's License #: _____

Patient Employer: _____ Employer Phone #:_____

Occupation: _____ Preferred language: _____

Race: □Decline to State □White □Black □Asian □Alaska Native
□American Indian □Native Hawaiian □Other Pacific Islander
Ethnicity: □Decline to State □Hispanic or Latino □Non-Hispanic or Latino

Contact Information

Cell #: _____ Work #: _____ Ext: _____

Home #: _____ E-Mail Address: _____

Best time and place to reach you: _____

May we communicate with you via: phone: Y/N text message: Y/N email: Y/N

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Spouse's Name: _____ Spouse's D.O.B: _____

Spouse's Employer: _____ Spouse's Occupation: _____

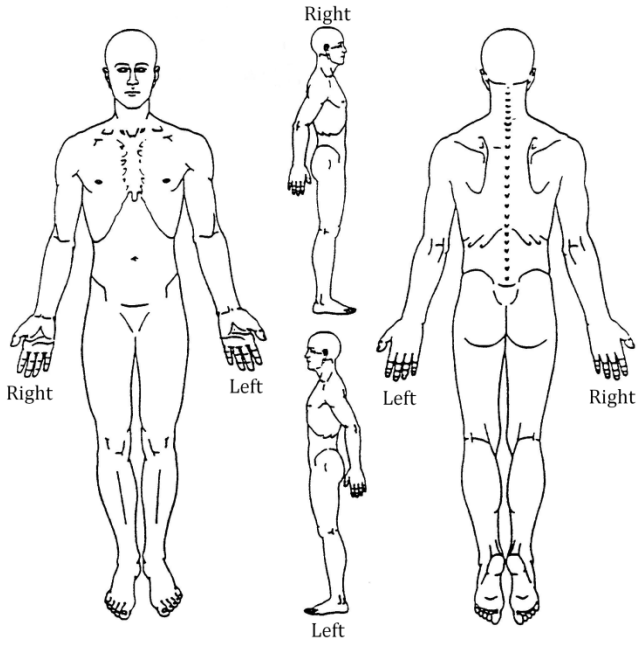
Number of Children: _____ Ages: _____

Emergency Contact

Name: _____ Relationship: _____

Cell Phone: _____ Alt. Phone: _____ Ext: _____

Please mark an X on the picture in all the places where you have pain, numbness, stiffness, or tingling.



Please describe your symptoms and/or discomfort in detail:

For your symptoms and discomfort, please use the following Pain Scale from 1 to 10:

Pain Scale: [No Pain] [Annoying] [Aggravating] [Debilitating]
Level: 0 1 2 3 4 5 6 7 8 9 10

Area 1: _____ **Discomfort/Pain Level at its worst:** _____**Today**: _____

Quality of Discomfort: dull ache burn throb sharp stab numb tingle tight Other: _____

If qualities have different frequencies, please explain: (i.e.: constant numb, frequent sharp…)_____

_____

Frequency: Constant (100-75%) Frequent (75-50%) Intermittent (50-25%) Occasional (25-1%)

Radiates: No Yes:_____ **Worsened by?** _____**Relieved by?** _____

Activities affected? Sleep Care Travel Work Recreation Lifting Walking Standing Sitting Other: _____

Additional info about condition:_____

Area 2: _____ **Discomfort/Pain Level at its worst:** _____**Today**: _____

Quality of Discomfort: dull ache burn throb sharp stab numb tingle tight Other: _____

If qualities have different frequencies, please explain: _____

_____

Frequency: Constant (100-75%) Frequent (75-50%) Intermittent (50-25%) Occasional (25-1%)

Radiates: No Yes:_____ **Worsened by?** _____**Relieved by?** _____

Activities affected? Sleep Care Travel Work Recreation Lifting Walking Standing Sitting Other: _____

Additional info about condition: _____

Area 3: _____ **Discomfort/Pain Level at its worst:** _____**Today**: _____

Quality of Discomfort: dull ache burn throb sharp stab numb tingle tight Other: _____

If qualities have different frequencies, please explain: _____

_____

Frequency: Constant (100-75%) Frequent (75-50%) Intermittent (50-25%) Occasional (25-1%)

Radiates: No Yes:_____ **Worsened by?** _____**Relieved by?** _____

Activities affected? Sleep Care Travel Work Recreation Lifting Walking Standing Sitting Other: _____

Additional info about condition:_____

Area 4: _____ **Discomfort/Pain Level at its worst:** _____**Today**: _____

Quality of Discomfort: dull ache burn throb sharp stab numb tingle tight Other: _____

If qualities have different frequencies, please explain: _____

_____

Frequency: Constant (100-75%) Frequent (75-50%) Intermittent (50-25%) Occasional (25-1%)

Radiates: No Yes:_____ **Worsened by?** _____**Relieved by?** _____

Activities affected? Sleep Care Travel Work Recreation Lifting Walking Standing Sitting Other: _____

Additional info about condition: _____

Area 5: _____ **Discomfort/Pain Level at its worst:** _____**Today**: _____

Quality of Discomfort: dull ache burn throb sharp stab numb tingle tight Other: _____

If qualities have different frequencies, please explain: _____

_____

Frequency: Constant (100-75%) Frequent (75-50%) Intermittent (50-25%) Occasional (25-1%)

Radiates: No Yes:_____ **Worsened by?** _____**Relieved by?** _____

Activities affected? Sleep Care Travel Work Recreation Lifting Walking Standing Sitting Other: _____

Additional info about condition: _____

Is there anything else you would like to tell the doctor: _____

_____

_____

Health History

Are your present problems due to an injury? □Yes □No Enter the date of the injury: _____

Was the injury? □ Job Related □Auto Accident □Personal Injury □Other: _____

Has the accident been reported? □Yes □No If so, to whom? □To Employer □Auto Carrier □Other: _____

Briefly describe the accident, injury or condition:_____

_____

When did your symptoms appear?:_____

Is your condition getting progressively worse? □Yes □No □Unknown

Were you admitted to the hospital due to this condition: □Yes □No If yes, what hospital? _____

Transported by? □Ambulance □Police □Other: _____ Date Admitted: _____

Date Released: _____ Length of Stay: _____ List the hospital procedures received:_____

List any tests, studies or medications received for this condition:

□Tests/Studies: _____□Medications: _____

What type of work do you do? _____

Work Activity: □Sitting □Standing □Light Labor □Heavy Labor

Do you have any current work restrictions due to this condition? Light duty:□Yes □No □Previously

(If yes, what are/were your restrictions?) _____

Have you missed any days from work due to this condition? □ Yes □ No How many?_____

Off work: □Yes □No □Previously From: _____ To: _____

Have you ever had Chiropractic care before? □ Yes □ No Where/When?_____

What treatment have you already had for your current condition?

□Medication □Chiropractic Care □Surgery □Physical Therapy □None □Other _____

Name of other doctors who have treated you for this condition: _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the surgery and approximate date.)

_____

_____

_____

Have you ever had X-rays or MRI taken? ❑Yes ❑No When? _____ By Whom?_____

For what ailments were these X-rays taken?

_____

Primary Care Physician: _____

HABITS: **Smoking:**

❑Current Every Day Smoker ❑Current Some Day Smoker ❑Former Smoker ❑Never Smoker

Drinking:

❑Alcohol: (drinks/day): _____ ❑Coffee: (Cups/Day): _____ ❑Soda: (Bottles or Cans/Day): _____
❑Water: (Cups/Day): _____

Exercise: ❑None ❑Moderate ❑Daily

FAMILY HISTORY	Diabetes	Cancer	Back Pain	Other	
Mother	❑	❑	❑	❑	_____
Father	❑	❑	❑	❑	_____
Sibling(s)	❑	❑	❑	❑	_____

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following, and print clearly:

Medication: _____
Route: Oral Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Women Only

Date of last menstrual period: _____

Is there a possibility that you are pregnant? ☐ Yes ☐ No

*** I understand that the examination I am having involves radiation, and that radiation may cause injury to the unborn fetus, although the likelihood of such injury is slight. My physician feels that the information to be gained from the examination is important to my health, and I therefore wish to have X-Rays performed.

If you think you might be pregnant, please inform the Technologist prior to the examination.

Patient Signature: _____ Date: _____

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EENT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

Insurance and Financial Information

Who is responsible for this account? _____Relationship to patient: _____

Health Insurance Company Name: _____ ID #: _____

2nd Health Insurance Company Name: _____ ID #: _____

Work/Auto Accident Denial: I confirm that the treatment I am requesting to receive today is NOT for injuries sustained in an automobile accident or work-related accident.

Patient Signature: _____ Date: _____

If MVA:

Auto Insurance Company Name: _____ Phone # _____

Claim #: _____Adjuster Name: _____Phone # _____

****

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company. I understand that any amount authorized to be paid directly to this chiropractic 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 I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

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It is our office policy to make certain that we provide all persons with a complimentary consultation in order to determine if theirs is a chiropractic problem.

Cost Estimates

New Patient Exam	$100.00
X-Rays	$45.00 - $270.00
Non-Surgical Spinal Decompression	$75.00
Interim/Update Examination	$60.00
MLS Robotic Cold Laser (per body area)	$55.00
Chiropractic Adjustment	$50.00
Care Coordination and Counseling	$40.00
Interferential Stimulation Therapy	$25.00
Intersegmental Traction Therapy	$20.00
Kenisio Taping	$15.00-$30.00

All cases vary. The doctor will handle patients on a case to case basis, therefore charges may vary.

****

If you understand and agree with all of the above office policies, please sign below.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____

Doctor's Signature _____