DATE:____/____/____

## CONFIDENTIAL PATIENT INFORMATION

*PLEASE PRINT*

**PATIENT INFORMATION:**

FULL NAME___________________________D.O.B.____/____/____ AGE____Male☐ Female ☐

ADDRESS_______________________________ APT#________ SSN_____-____-_____

CITY___________________ STATE_____ ZIP________ HOME PHONE (____)___________

ALT. PHONE (CELL) (____)___________ EMAIL ADDRESS_________________________

EMPLOYER'S NAME________________________
OCCUPATION_______________________

WORK ADDRESS______________________ CITY___________ STATE_____ ZIP______

WORK PH. # (____)___________ EXT.______ DATE SYMPTOMS BEGAN ___/___/___

MARITAL STATUS: SINGLE☐ MARRIED☐ DIVORCED☐ WIDOWED☐

**HOW DID YOU HEAR ABOUT US?**

☐ Referral: Let us know who to thank:____________________________
☐ Postcard
☐ Google Search: Do you remember what you searched ________________________
☐ Walk-in
☐ Our Website
☐ Other:____________________

EMERGENCY CONTACT _____________________________ PHONE (___)___________

**AUTHORIZATIONS:**

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself of to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____________________________________ Date:_______________

Guardian Signature: ______________________________________ Date: _______________

# HEALTH QUESTIONNAIRE-HISTORY

Patient's Name

## E. REVIEW OF SYSTEMS

**Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.**

- ○ **None** Of The Symptoms Listed Below
- ○ **No New** Symptoms Since Your Last Exam

- ○ General Fatigue
- ○ Weakness
- ○ Fever (continuous)
- ○ Loss Of Sleep
- ○ Chills (continuous)
- ○ Weight Change (unplanned)
- ○ Night Sweats
- ○ Headaches
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Nervousness
- ○ Anxiety
- ○ Depression (prolonged)
- ○ Phobias (excessive fears)
- ○ Memory Loss Or Impairment
- ○ Mood Swings (excessive)

| | Left | Right |
|---|---|---|
| Hearing Trouble | ○ | ○ |
| Ringing in Ears | ○ | ○ |
| Pain in Ears | ○ | ○ |
| Ear Discharge | ○ | ○ |
| Vision Trouble | ○ | ○ |
| Pain in Eyes | ○ | ○ |
| Eye Discharge | ○ | ○ |

- ○ Nose/Sinus Pain
- ○ Excessive Drainage
- ○ Nose Bleeds (chronic)
- ○ Nasal Infections (chronic)
- ○ Absence Of Smell
- ○ Mouth Sores
- ○ Bleeding Gums
- ○ Enlarged Glands
- ○ Absence Of Taste
- ○ Abnormal Taste Sensation
- ○ Tonsillitis/Infected Tonsils
- ○ Difficulty With Swallowing
- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter (enlargedThyroid gland)
- ○ Tremor (shaking)
- ○ Skin Rash
- ○ Redness Of Skin
- ○ Skin Itching
- ○ Skin Dryness
- ○ Eczema(red, inflamed skin)
- ○ Hair Changes (unplanned)
- ○ Nail Changes (unplanned)
- ○ Bruise Easily
- ○ Cough (chronic)
- ○ Wheezing (chronic)
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Varicosities (visible veins)
- ○ Rapid Heart Beat
- ○ Chest Pain
- ○ Heart Palpitations
- ○ Heart Murmur
- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Hemorrhoids
- ○ Excess Gas
- ○ Vomiting (excessive)
- ○ Diarrhea (excessive)
- ○ Constipation (excessive)
- ○ Heartburn/Indigestion
- ○ Painful Urination
- ○ Inability To Hold Urine
- ○ Frequent Urination
- ○ Urinary Retention
- ○ Bed-wetting
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Sterility
- ○ Impotence
- ○ Lumps In Breast(s)
- ○ Redness/Itching of Breast
- ○ Dimpling of Breast(s)
- ○ Discharge from Breast(s)
- ○ Breast Pain

○ Other (Please Describe)

## F. HABITS/ACTIVITIES

**What Are Your Current Habits?**

| | | Never | ≤1 | 1-2 | 2-3 | 3-4 | 5+ |
|---|---|---|---|---|---|---|---|
| Smoking | Packs Per Day | ○ | ○ | ○ | ○ | ○ | ○ |
| Caffeinated Drinks | Glasses Per Day | ○ | ○ | ○ | ○ | ○ | ○ |
| Alcohol Consumption | Glasses Per Day | ○ | ○ | ○ | ○ | ○ | ○ |

Drug/Substance Abuse.. No ○ Yes ○ **If Yes, Discuss With Doctor**

| | | Never | ≤1 | 1-2 | 2-3 | 3-4 | 5+ |
|---|---|---|---|---|---|---|---|
| Exercise | Days Per Week | ○ | ○ | ○ | ○ | ○ | ○ |

Kinds Of Exercise You Do:

○ Walking ○ Jogging ○ Cycling ○ Swimming
○ Golf ○ Tennis ○ Strength Training
○ Other:

## G. MEDICAL HISTORY

### 1.HEALTH CARE

a. **Have You Ever Been To A Chiropractor?** Yes ○ No ○

b. **Do You Have A Family Physician** Yes ○ No ○
Date Of Last Physical Exam:
Physician's Name:
Address:
Phone:( )

c. **Have You Been Hospitalized In The Past?** Yes ○ No ○
Date & Reason For Hospitalization:

d. **Have You Ever Had Surgery?** Yes ○ No ○
Date, Reason, Results Of Surgery:

e. **Have You Ever Had A Serious Accident/Injury?** Yes ○ No ○
List Date & Describe Injury:
○ Auto:
○ Work-Related:
○ Personal:
○ Sports Injury:
○ Other:

f. **Are You Currently Taking Any Vitamins, Minerals, Or Herbs?** (List Supplements) Yes ○ No ○

g. **Are You Currently Taking Any Medications?** Yes ○ No ○
For What Condition(s) Are You Taking Medication?
○ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):
○ Pain/Analgesics:
○ Anti-Depressants:
○ Muscle Relaxants:
○ Blood Pressure Pills:
○ Antibiotics:
○ Birth Control Pills:
○ Corticosteroid:
○ Other:

**In The Past Have You Use Any Of The Following?**
○ Birth Control Pills ○ Corticosteroid

h. **Are You Allergic To Any Medications?** Yes ○ No ○
List Medications:

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## G. MEDICAL HISTORY - CONTINUED

**1i. WOMEN ONLY:**

| | Yes | No |
|---|---|---|
| To Your Knowledge, **Are You Pregnant?** | ○ | ○ |
| If Pregnant In Past, Were Pregnancies Normal? | ○ | ○ |
| Are You Seeing An OB-GYN Regularly? | ○ | ○ |

Number Of Births: ① ② ③ ④ ⑤ ○ Other:___

Date Of Last Exam:

Physician's Name:

Address:

Phone:( )

## 2. FAMILY HISTORY

| | Cancer | Diabetes | Heart Trouble | High Blood Pres | Stroke | Kidney Disease | Anemia | Mental Illness | Headaches | Osteoporosis | Arthritis | Joint Problems | Scoliosis | Back Problems | Disc Problems | Congenital Defects | Genetic Disease | Other | Deceased? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | C | D | H | H | S | K | A | M | H | O | A | J | S | P | D | C | G | O | D |
| Mother | C | D | H | H | S | K | A | M | H | O | A | J | S | P | D | C | G | O | D |
| Brothers | C | D | H | H | S | K | A | M | H | O | A | J | S | P | D | C | G | O | |
| Sisters | C | D | H | H | S | K | A | M | H | O | A | J | S | P | D | C | G | O | |
| Children | C | D | H | H | S | K | A | M | H | O | A | J | S | P | D | C | G | O | |

Describe Others:

## 3. Conditions Or Illnesses

**Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:**

○ ***No Current Or Previous Conditions/Illnesses***

| Now Have | In Past | Condition | Now Have | In Past | Condition |
|---|---|---|---|---|---|
| H | P | Sinus Trouble | H | P | Kidney Trouble |
| H | P | Hay Fever | H | P | Urinary Retention |
| H | P | Allergies | H | P | Frequent Urination |
| H | P | Asthma | H | P | Prostate Trouble |
| H | P | Emphysema | H | P | Arthritis |
| H | P | Tuberculosis | H | P | Osteoporosis |
| H | P | History of Infection | H | P | Scoliosis |
| H | P | Fever (Continuous) | H | P | Dislocated Joints |
| H | P | Cancer/Tumor | H | P | Spinal Disc Disease |
| H | P | Diabetes | H | P | Bone Fracture (list/dates): |
| H | P | Visual Disturbances | | | |
| H | P | Dizziness/Fainting | | | |
| H | P | Epilepsy/Seizures | | | |
| H | P | Thyroid Trouble | H | P | Mental/Emotional Difficulty |
| H | P | High Blood Pressure | H | P | Sex. Trans. Diseases |
| H | P | Low Blood Pressure | H | P | HIV |
| H | P | Heart Trouble | H | P | AIDS/ARC |
| H | P | Pacemaker | H | P | Abnormal Weight Gain |
| H | P | Stroke [date_________] | H | P | Abnormal Weight Loss |
| H | P | Aortic Aneurysm | H | P | Numbness Groin/Buttocks |
| H | P | Anemia | H | | Other: |
| H | P | Rheumatic Fever | | | |
| H | P | Polio | | | |
| H | P | Multiple Sclerosis | | P | Other: |
| H | P | Ulcer | | | |
| H | P | Liver Trouble | | | |

## H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

**1. Are You Right Or Left Handed?** ○ Right ○ Left

**2. Job Type**

○ Retired ○ Unemployed ○ Full-Time Student

**If Any Of Above Skip Rest, Sign At Patient's Signature**

○ Full Time ○ Part Time ○ Temporary

○ Self-Employed ○ Other

**3. During Your Work Week, You Work How Many:**

Hours Per Day ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

Days Per Week ① ② ③ ④ ⑤ ⑥ ⑦

○ Other

**4. How Long Have You Been With Your Present Employer?**

Years ⑩ ⑳ ㉚ ㊵ ㊿

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Months ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪

**5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day?** ○ Yes ○ No

**6. What Is Your Primary Work Position and Location?**

**a. Work Position:** ○ Seated ○ Standing ○ Other

**b. Work Location:** ○ Desk ○ Counter ○ Workbench ○ Other

**7. What Movements Does Your Job Require?**

○ Bending ○ Turning ○ Stooping

○ Twisting ○ Walking ○ Repetitive Hand Use

○ Carrying ○ Other

**8. Does Your Work Include Any Of The Following Use?**

○ Prolonged Computer ○ Continuous Phone

**9. Does Your Job Involve Lifting?**

○ Never ○ Occasionally ○ Intermittently

○ Frequently ○ Constantly

**How Many Pounds? (Choose Only One)** 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90 ○ 100+ ○ Pounds

**10. What Best Describes Your Stress Level At Work?**

○ None ○ Minimal ○ Minimal To Moderate

○ Moderate ○ Moderate To Extreme ○ Extreme

**11. How Do You Rate Your Physical Activity At Work?**

○ Seated more than 50% of workday

Manual Labor: ○ Light ○ Light To Moderate ○ Moderate ○ Moderate To Heavy ○ Heavy

**12. Do Work Activities Aggravate Your Present Complaints?**

○ Yes ○ No **If Yes, Explain:**

**PATIENT'S SIGNATURE** **DATE:**

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PLEASE MAKE NO MARKS IN THIS AREA

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