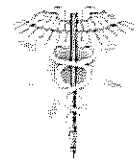
PERSONAL HISTORY

(PLEASE PRINT)



Name_____ Date_____

Mailing Address_____ Apt#_____ City_____ St_____ Zip_____

E-Mail Address:_____

Home PH#_____ _____ Cell PH#_____ _____ Work PH#_____ _____

SS#_____-_____-_____ Medicare#_____-_____-_____ Sex ☐ F ☐ M

Birth Date:(M)_____(D)_____(Yr)_____ Age_____ Number of children_____ Marital status ☐ S ☐ M ☐ W ☐ D

Occupation_____ Employer_____ # of years_____

Address_____ City_____ State_____ Zip_____

☐ Spouse or ☐ Parent (if minor)_____ Birth Date:(M)_____(D)_____(Yr)_____SS#_____

Address_____ City_____ State_____ Zip_____

Employer_____ PH#_____-_____

Emergency Contact (Not living with you)_____ Relationship_____

Address_____ PH#_____-_____

How did you find out about our office? ☐Newspaper ☐Mail out ☐Phonebook ☐TV ☐Other ☐Referral_____

History of Present Illness

Location of complaint (where is the pain/problem)_____

Do you have family members with the same or similar condition? ☐ Yes ☐ No If yes explain:_____

Cause of condition? ☐ Cause unknown ☐ Slip and Fall ☐ Genetic ☐ Auto accident ☐ Illness_____

☐ Employment injury ☐ Other_____

Duration Date condition began:_____ Have you had this condition before? ☐ No ☐ Yes, when_____

Quality of pain ☐ Sharp ☐ Throbbing ☐ Dull ☐ Aching ☐ Shooting ☐ Burning ☐ Cold ☐ Cramping ☐ Prickling

☐ Other_____

Do you have numbness/tingling ☐ No ☐ Yes, where_____

Severity (0 = no pain 3= most severe) 0 1 2 3 Other_____

Timing of Pain ☐ Comes and goes ☐ Is constant ☐ Worse at night ☐ Other_____

Modifying Factors What has helped your condition? _____

What makes the condition worse?_____

Sleep ☐ Well ☐ Off / On ☐ Poor ☐ None ☐ Too much ☐ Other_____

Associated Signs/Symptoms (what other health problems are you having?)_____

Condition is ☐ Getting worse ☐ Getting better ☐ Staying the same

Are you working? ☐ Yes ☐ No Date last worked_____ **Previous chiropractic care?** ☐ Yes ☐ No, when_____

Previous treatment ☐ Prescription medication ☐ Over the counter medication ☐ Surgery ☐ Physical therapy

☐ Other_____ When_____

Name of other doctor(s) that have treated you for this condition:

Dr _____ City_____

Dr _____ City_____

List dates of any previous accidents:

Date_____ ☐ Auto ☐ Slip / Fall ☐Work/Comp ☐ Other Describe_____

Date_____ ☐ Auto ☐ Slip / Fall ☐Work/Comp ☐ Other Describe_____

Please complete the reverse side

Health History

Have you recently been treated for other conditions? ☐ No ☐ Yes, what?_____

Treating Physician _____

Drugs ☐ Prescription _____

☐ Over the counter_____

Do you take vitamins? ☐ No ☐Yes What kind?_____

Previous hospitalizations/surgeries/serious illnesses/other doctors you have seen

Please describe	When	Where	Doctor

Are you Pregnant ? (women) ☐ Yes ☐ No **Are you taking birth control pills?** (women) ☐ Yes ☐ No

Review of Systems: (Check only those condition which relate to your medical history)

Neurological:	☐ Frequent headaches _____	☐ Paralysis on one side _____
	☐ Numbness on one side _____	☐ Slurred speech _____
	☐ Double vision _____	☐ Loss of consciousness _____
	☐ Incoordination _____	☐ Stroke _____
General:	☐ Fever _____	☐ Weight loss _____
	☐ Excessive tiredness _____	☐ AIDS or HIV+ _____
	☐ Cancer _____	☐ Hepatitis _____
	☐ Diabetes _____	☐ Tuberculosis _____
Eyes:	☐ Blindness _____	☐ Cataract _____
	☐ Glaucoma _____	☐ Sudden loss of vision in one eye _____
Ears:	☐ Hearing loss _____	☐ Recurrent ear infections _____
	☐ Vertigo _____	
Throat:	☐ Swallowing difficulty _____	☐ Jaw pain on chewing _____
Cardiac:	☐ Chest pain _____	☐ Heart attack _____
	☐ Irregular heartbeat _____	☐ High blood pressure. _____
	☐ Pacemaker _____	
Respiratory:	☐ Shortness of breath _____	☐ Persistent cough _____
	☐ Blood in sputum _____	
Gastrointestinal:	☐ Diarrhea _____	☐ Stomach pain _____
	☐ Constipation _____	☐ Vomiting _____
	☐ Blood in stool _____	☐ Tarry stools _____

Social History

Use of tobacco ☐ Never ☐ Previously, but quit ☐ Yes _____ packs a day

Use of recreational drugs ☐ Never ☐ Type/frequency _____/_____

Use of alcohol ☐ Never ☐ Previously, but quit _____ ☐ Rarely ☐ Moderate ☐ Daily

Do you exercise? ☐ No ☐ Yes, _____light _____Moderate _____Heavy ____Walk ____Jog Other_____

Daily work habits include ☐ Long hours sitting ☐ Light labor ☐ Heavy labor ☐ Long hours standing ☐ Heavy lifting ☐ Computer work

☐ Other _____

Excessive exposure to ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise ☐ Other_____

Insurance Information

Most insurance policies provide chiropractic coverage, and we accept assignment of benefits on nearly all policies
If you would like our insurance department to verify your chiropractic benefits, please present your insurance card to the reception desk

☐ Self Pay ☐ Group Policy ☐ Government Health Plan ☐ Medicare ☐ Medicare Replacement Plan ☐ Auto ☐ Work/Comp
☐ Personal Injury ☐ Other_____

Please present your insurance card(s) to determine available chiropractic benefits.

_____
Signature