

PERSONAL HISTORY

Name: Birth Date: Age: Sex: Address: Social Security # (Optional): City: Driver's License Number: State/Prov: Zip/Postal Code: E-mail Address: Home Phone: Cell Phone: Are You: Married Single Widowed Divorced Business Employer: Name of Spouse: Type of Work: Business Phone: Referred to this office by: Name of Emergency Contact: Relationship: Phone Number: Who Is Responsible For Payment? Yourself Spouse Auto. Insurance Insurance Work. Comp. Medicare Medicaid Personal Health Insurance (Name): Health Card #: Insured Person's Name: Date of Birth:

CURRENT HEALTH CONDITION

Reason(s) for Today's Visit:

Other Doctors Seen For This Condition: Yes No Who?

Type of Treatment(s):

Results:

When Did This Condition Begin?

Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other:

Date of Accident: Time of Accident:

Have You Made A Report to Your Employer? Yes No

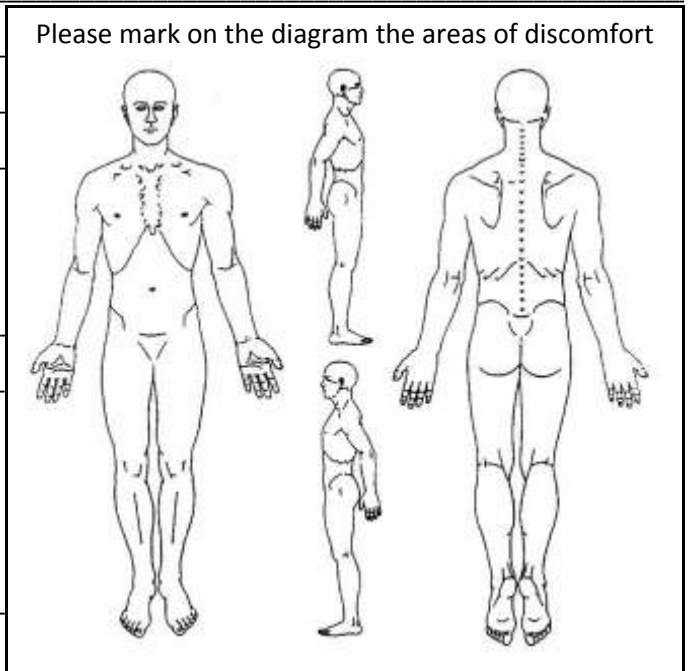
Drugs You Now Take: Nerve Pills Pain Killers

Muscle Relaxers Blood Pressure Medicine Insulin

Other:

Do You Wear A Shoe Lift? Yes No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?





PAST HEALTH HISTORY

If Applicable, Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones

Other: _____

Major Accidents of Falls: _____

Hospitalizations (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | | |
|--|--|--|--------------------------------------|-----------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> High Blood Pressure | INTAKE: | PER DAY: |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee/Tea | _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Soda | _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol | _____ |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tobacco | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Eczema | <input type="checkbox"/> White Sugar | _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Tested HIV positive | | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULOSKELETAL PROBLEMS

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Leg Pain
- Joint Pain
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM PROBLEMS

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling in Extremities
- Stress

EYES, EARS, NOSE, THROAT PROBLEMS

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Sinus Infections

GENERAL PROBLEMS

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTROINTESTINAL PROBLEMS

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITOURINARY PROBLEMS

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

HEART/CHEST/VASCULAR PROBLEMS

- Chest Pain
- Shortness of Breath
- High Blood Pressure
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

MALE/FEMALE PROBLEMS

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

FEMALES ONLY:

When was your last period? _____
 Are you pregnant? Yes No Not Sure

FAMILY HISTORY

The following members have the same or similar problem as I do:
 Mother Brother Spouse
 Father Sister Child

PATIENT GOALS & OBJECTIVES

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem *as well as* the symptoms corrected and relieved (Corrective Care). After either of those objectives are met, a third type of care, Maintenance Care, is recommended to prevent recurrence and promote health. Often times, patients will seek Chiropractic for solely Maintenance/Preventive Care.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

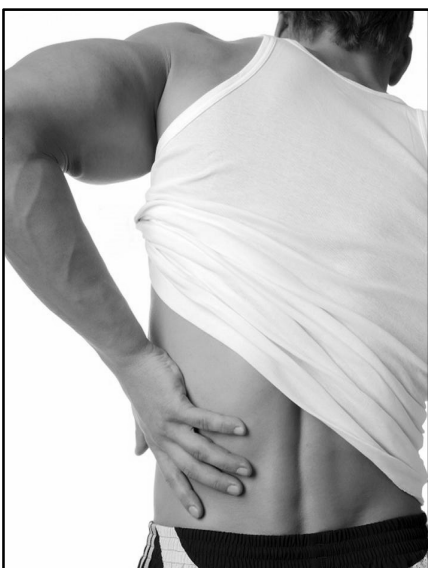
Relief Care Corrective Care Maintenance/Preventive

Check here if you want the Doctor to select the type of care appropriate for your condition

Patient's Signature

Date

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's 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 that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____