

# CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: (Last, First, MI) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Gender: M / F Marital Status: Married / Single / Other

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse/Significant Other: \_\_\_\_\_ Children and Ages: \_\_\_\_\_

Are you: Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

Referred by (name): \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

*-CMS requires providers to report both race and ethnicity-*

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer Preferred Language: \_\_\_\_\_

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

Full Name: \_\_\_\_\_ Preferred Contact Number: \_\_\_\_\_

Relationship: Child / Parent / Spouse / Other: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

## FINANCIAL INFORMATION -- *Please allow us to photocopy your insurance card.*

Self Pay (Cash) Insurance Personal Injury/Auto Other (please explain) \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Relation to Insured: Self / Spouse / Parent / Child / Other

Relation to Insured: Self / Spouse / Parent / Child / Other

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

**CURRENT CONDITION INFORMATION**

*PLEASE ANSWER ALL QUESTIONS*

**Major Complaint:** \_\_\_\_\_

**When Did It Start (date):** \_\_\_\_\_ **What Event Caused It:** \_\_\_\_\_

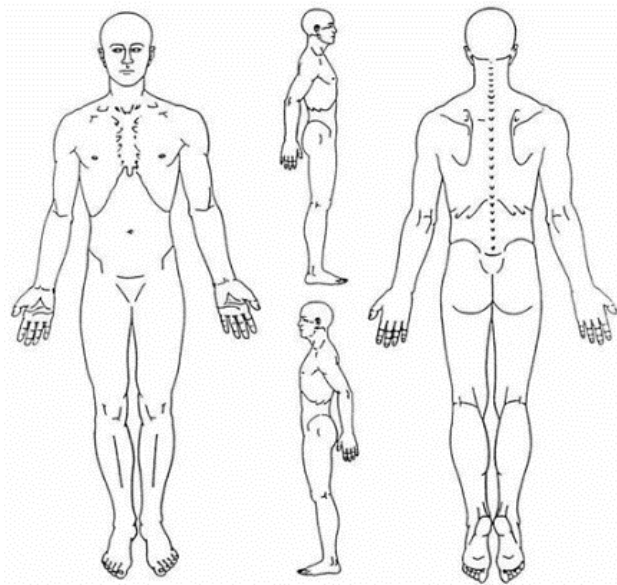
**Intensity:** None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

**Is The Complaint:** Constant / Off and On

**Is The Complaint:** Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other: \_\_\_\_\_

**Does It Radiate/Shoot To Any Areas Of Your Body?** No / Yes **If YES, where:** \_\_\_\_\_

**DRAW AREAS OF COMPLAINTS:**



**What Makes It Better?** Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

**What Makes It Worse?** Sit / Stand / Walk / Lying / Sleep / Movement

**Who Else Have You Seen For This?** No One / DC / MD / PT / Massage / ER / Other: \_\_\_\_\_

**- Where:** \_\_\_\_\_

**Diagnostic Tests:** None / X-rays / MRI / CT / Other: \_\_\_\_\_ **When and Where:** \_\_\_\_\_

**Any Other Complaints:** \_\_\_\_\_

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

Does anyone in your IMMEDIATE family have a history of (circle condition):  NONE

Heart Disease If yes, who \_\_\_\_\_ Stroke If yes, who \_\_\_\_\_

Cancer If yes, who \_\_\_\_\_ Type \_\_\_\_\_ Other Relevant Family History: \_\_\_\_\_

PAST HEALTH HISTORY: (List even if it was 20 years ago...)

Injuries, Traumas or Hospitalizations:  NONE \_\_\_\_\_

Surgeries – Date, Type and Reason:  NONE \_\_\_\_\_

Current Medications: Did you bring a list? Can we make a copy?  NONE \_\_\_\_\_

Allergies to Medications: (List and reactions)  NONE Vitamins & Supplements: (List all and frequency)  NONE

Are you **CURRENTLY** experiencing any of these symptoms? (Check all that apply)

**General:**

- Recent Intentional Weight Change
- Fever
- Fatigue
- None in this Category

**Musculoskeletal:**

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems
- Leg Problems
- Broken Bones
- Muscle Spasms/Cramps
- None in this Category

**Neurological:**

- Numbness or Tingling Sensations
- Loss of Feeling
- Dizziness or Light Headed
- Frequent or Recurrent Headaches
- Convulsions or Seizures
- Have you ever had a head injury?
- Had an auto accident? Year: \_\_\_\_\_
- None in this Category

**Gastrointestinal:**

- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Constipation
- None in this Category

**Cardiovascular & Heart:**

- Chest Pains
- Rapid or Heartbeat Changes
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- None in this Category

**Respiratory:**

- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Tobacco Use
- None in this Category

**Eyes and Vision:**

- Wear Contacts/Glasses
- Blurred or Double Vision
- Eye Disease or Injury
- None in this Category

**Ears, Nose and Throat:**

- Swollen Glands in Neck
- Ringing in the Ears
- Ear-Ache/Ringing/Drainage
- Sinus/Allergy Problems
- None in this Category

**Mind/Stress:**

- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- None in this Category

**Endocrine, Hematologic, and Lymphatic:**

- Thyroid Problems
- Diabetes
- Cold Extremities
- Heat or Cold Intolerance
- Immune System Disorder
- None in this Category

**Skin and Breasts:**

- Rash or Itching
- Non-healing Sores
- Breast Pain
- Breast Lump
- Breast Discharge
- None in this Category

**Genitourinary:**

- Kidney Stones
- Burning/Painful Urination
- Change in Force/Strain w/Urination
- Frequent Urination
- Urinary Leakage or Bed Wetting
- Blood in Urine
- None in this Category

**Women Only:**

**Are you pregnant?**

- Yes-Due Date: \_\_\_\_\_
- No-Last Menstrual Period: \_\_\_\_\_
- Painful or Irregular Periods
- Urine Leakage with Coughing or Sneezing
- Urine Leakage with Laughing or Lifting
- None in this Category

**Pregnancies with Outcome & Date**

\_\_\_\_\_  
\_\_\_\_\_

Other Conditions not listed: \_\_\_\_\_

Is there anything else you would like the doctor to know? \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

# AUTO ACCIDENT QUESTIONNAIRE

Print Name (First MI Last) \_\_\_\_\_ Date \_\_\_\_\_

## ACCIDENT INFORMATION (Please use back of this page if needed.)

Date of Accident: \_\_\_\_\_ Number of People in Your Vehicle \_\_\_\_\_ Name of Driver (if not you) \_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Were you wearing a seatbelt?  Yes  No

Where was your vehicle impacted?  Front  Rear  Driver side  Passenger side

## MEDICAL INFORMATION

### At the Time of the Accident

Did you feel pain immediately after the accident?  Yes  No

If no, when?  Later that Day  Next Day  When? \_\_\_\_\_

Did you go to a hospital or see any other doctor?  No  Yes

If yes, when did you go?  Immediately  Next Day  Other

Name of hospital and/or doctor: \_\_\_\_\_

Were any x-rays taken?  Yes  No

### Since the Accident

Are your symptoms:  Getting Better  Staying the Same  Getting Worse

## LEGAL INFORMATION

Was a police report filed?  Yes  No

Have you retained an attorney?  No  Yes

If yes, name of attorney \_\_\_\_\_ Phone \_\_\_\_\_

Your Auto Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Other Auto Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_

## OFFICE POLICIES FOR PERSONAL INJURY PATIENTS

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. To extend you credit while you are under treatment, you must provide the appropriate financial information so that payment for services can be received. Patients must bring the following information by the third office visit or pay for their treatment.

1. Copy of police report and/or a copy of the exchange slip.
2. Name of individual and insurance company of party that is liable.
3. Copy of personal automobile policy.
4. Name and telephone number of attorney, if one has been retained.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility and will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

*I have answered these questions to the best of my knowledge and certify them to be true and correct.*

Patient or Guardian Signature \_\_\_\_\_