

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): _____ Social Security Number: _____

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 This Episode Start (date): _____ **What Event Caused It:** _____

If this is NOT the first time, how long has this been a recurring problem? _____

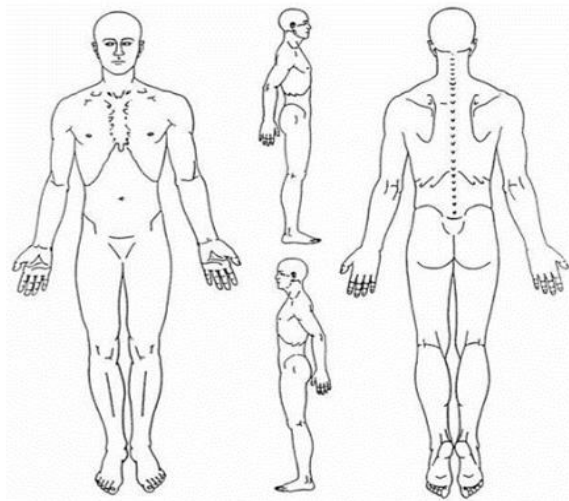
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

The Complaint is: Constant / Comes and Goes

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 _____