PERSONAL HISTORY

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

S.S.#: _____ Email Address: _____

Birth Date: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Check One: Married Single No. of Children: _____

Business/Employer: _____ Type of Work: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill, You and: Spouse Health Insurance Medicare Other

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Major Complaint: _____

When did this condition begin? _____ If Accident, Injury Date: _____

Origin of Condition: Unknown Sports Injury Work Injury Auto Accident Fall

What worsens this condition? _____ What offers relief? _____

Describe how you feel when the pain is at its worst: _____

_____

Does this problem interfere with the following? Work Family Social Life Sports Hobbies

Please indicate pain level (circle): No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Other Doctor's Seen For This Condition: _____

If disabled from work, please give dates: _____

Are there others in your family with this same condition? _____

Current Medication(s): Pain Relievers Anti-Inflammatory Muscle Relaxants Aspirin (similar)

Blood Pressure Insulin Thyroid Anti-Depressants Birth Control Other _____

PAST HEALTH HISTORY

Major Surgery: Back Neck Heart Gall Bladder Hernia Cancer: _____

Major Accidents/Falls: _____

Hospitalizations (other than above): _____

Previous Chiropractic Care: (Dr.'s Name & Last Visit Date): _____

Have You Been Treated For Any Health Condition In The Past Year? Yes No

If Yes, Please Explain: _____

Below is a list of conditions which may effect your overall diagnosis, treatment plan and the possibility of being accepted for care. Please check off which of the following signs and symptoms apply. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

- ☐ Headaches
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Loss of Weight
- ☐ Arm/Hand Numbness
- ☐ Arm/Hand Pain
- ☐ Leg/Foot Numbness
- ☐ Leg/Foot Pain
- ☐ Neuralgia

GASTRO-INTESTINAL

- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Excessive Hunger
- ☐ Belching or Gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon Trouble
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Jaundice
- ☐ Gall Bladder Trouble

EYE-EAR-NOSE-THROAT

- ☐ Poor Vision
- ☐ Crossed Eyes
- ☐ Pain in Eyes
- ☐ Deafness
- ☐ Earache
- ☐ Ear Noises
- ☐ Ear Discharges
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Asthma/Wheezing
- ☐ Frequent Colds
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Sinus Trouble

RESPIRATORY

- ☐ Chronic Cough
- ☐ Spitting Blood
- ☐ Spitting Phlegm
- ☐ Chest Pain
- ☐ Difficulty Breathing

GENITO-URINARY

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Bed Wetting
- ☐ Urine Control Trouble
- ☐ Prostate Trouble

MUSCLES & JOINTS

- ☐ Weakness
- ☐ Twitching
- ☐ Stiff Neck
- ☐ Backache
- ☐ Swollen Joints
- ☐ Tremors
- ☐ Foot Troubles
- ☐ Painful Tailbone
- ☐ Mid/Upper Back Pain
- ☐ Hernia
- ☐ Spinal Curvature

CARDIO-VASCULAR

- ☐ Rapid Heart Beat
- ☐ Slow Heart Beat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain Over Heart
- ☐ Prior Heart Condition
- ☐ Ankle Swelling
- ☐ Poor Circulation
- ☐ Varicose Veins
- ☐ Stroke History

SKIN OR ALLERGIES

- ☐ Skin Eruptions
- ☐ Itching
- ☐ Bruise Easily
- ☐ Dryness
- ☐ Boils
- ☐ Sensitive Skin
- ☐ Hives
- ☐ Allergies (What?)
- ☐ Eczema
- ☐ Medicines
- ☐ Hay Fever

FOR WOMEN ONLY

- ☐ Painful Periods
- ☐ Excessive Flow
- ☐ Irregular Cycles
- ☐ Hot Flashes
- ☐ Cramps or Backache
- ☐ Miscarriage
- ☐ Vaginal Discharge
- ☐ Pregnant At This Time
- ☐ Last PAP Smear

Date: _____

Doctor: _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐

HABITS

- ☐ Smoking __ Pks/Day
- ☐ Alcohol __ Drinks/Day
- ☐ Soft Drinks __ Cans/Day
- ☐ Coffee __ Cups/Day
- ☐ Chocolate __ Ounces/Day

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily

_____

(Types of Exercise)

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ☐ Appendicitis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Cancer
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema
- ☐ Venereal Infection

WHY CHIROPRACTIC?

People go to chiropractors for a variety of reasons. Some go 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). Still others want whatever is malfunctioning in their bodies to be brought to the highest state of health possible with chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

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

☐ Relief Care ☐ Corrective Care ☐ Comprehensive ☐ Doctor's Recommendation

What do you expect to achieve with your care? _____

_____

On a scale from 1 to 10, (10 being the highest), how committed are you to correcting this problem? _____

The Purpose of Pinecrest Wellness Center is to support each individual's pursuance of optimum health and to educate them so that they may understand health and chiropractic and in turn educate others.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Further more, 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

PATIENT'S SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ DATE: _____