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

Who may we thank for referring you to our office? ____

-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) / Native Hawaiian or Pacific Islander / Other / Decline

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

EMERGENCY CONTACT INFORMATION

Full Name: ______________________________________

Home: ________________ **Mobile**: ___________________

Relationship: Child / Parent / Spouse / Other: ________

Name of Previous Chiropractor: ______________________________

Date of Last Chiropractic Adjustment: __________________________

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

Name: ____

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

Other than Self:
Insured's Name: _______________________ **Gender**: M / F

Address: ____

City: _________________ **State**: _________ **Zip**: ________

Phone: _______________ **Date of Birth**: ______________

SECONDARY INSURANCE

Name: ____

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

Other than Self:
Insured's Name: _______________________ **Gender**: M / F

Address: ____

City: _________________ **State**: _________ **Zip**: ___________

Phone: _______________ **Date of Birth**: _________________

List all Medications With Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

____

____

____

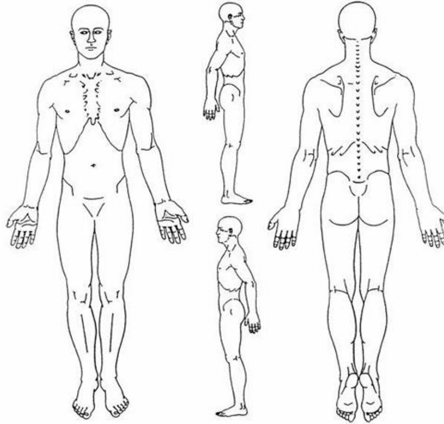
CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

What Bothers You The Most Today: ____

When Did It Begin (date):_______________ **How Did It Begin:** ____

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **Where:** ___________________________________

Draw Areas of Complaints:



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

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb

Is The Complaint: Constant / Off and On

What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds *(Advil, Tylenol, etc.)* / RX Meds

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:____

HEALTH HISTORY *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

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**:______________________

Allergies to Medications: *(List and reactions)*_______________

____

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

Surgeries – Date, Type and Reason:_______________________

____

____

____

Injuries, Traumas or Hospitalizations: *(Even 20 years ago or more)*

____

____

____

____

Vitamins & Supplements: *(List all and frequency)*_________

____

SOCIAL AND OCCUPATIONAL HISTORY:

Highest Level of Education:

High School / Some College / College Grad / Post Grad / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

____

Habits:

Cigarettes – (#/day/years) ______________________________

Alcohol – (amount/day)________________________________

Coffee/Tea – (cups/day)_______________________________

Rec. Drugs: (list) ______________________________________

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

General:
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _______________
- ❑ Leg Problems _______________
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: ____________________
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:________
- ❑ Other: ____________________
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: ____________________
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: ____________________
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: ____________________
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: ____________________
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: ____________________
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or Double Vision
- ❑ Glaucoma
- ❑ Eye Disease or Injury
- ❑ Other: ____________________
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Bleeding gums/Mouth sores
- ❑ Bad Breath or Bad Taste
- ❑ Dental Problems
- ❑ Swollen Throat or Voice Change
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: ____________________
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or cold Intolerance
- ❑ Change in hat or glove size
- ❑ Dry Skin
- ❑ Glandular or Hormone Problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: ____________________
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in Hair or Nails
- ❑ Non-healing Sores
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: ____________________
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date _______________
- ❑ No-Last Menstrual Period ______
- ❑ Infertility
- ❑ Painful or Irregular Periods
- ❑ Vaginal Discharge
- ❑ Other: ____________________
- ❑ *None in this Category*

Pregnancies with Outcome & Date

____

____

____

____

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________________

Treating Doctor Signature ____ Date ________________

ACCIDENT INFORMATION

Please PRINT clearly.

Today's Date: ______________

PATIENT INFORMATION

Name: (Last, First, MI) ____

Date of Accident: ________________ Time of Accident: ____________ Number of People in Your Vehicle:___ __________

ACCIDENT INFORMATION -- ***Please use back of this page if needed.***

Location/street of Accident:____

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

Name of Driver, *if not you* ___________________________ Name of Driver of other Vehicle: _____________________________

Make/Model of Vehicle you were in: ____

Is vehicle equipped with airbags? ☐ Yes ☐ No Did airbags inflate? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Where did the impact come from? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger Side

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the base

In what direction were you headed? ☐ North ☐ South ☐ East ☐ West

In what direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

During impact were you facing: ☐ Forward ☐ Backward ☐ Right ☐ Left

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No (Describe):_________________________________

____

Were you rendered unconscious? ☐ Yes ☐ No If yes, for how long? ___________

What was the approximate speed of your vehicle? ________ The other vehicle? ___________

Were you ☐ Aware ☐ Surprised by the impact? What did your vehicle impact? ☐ Another vehicle ☐ Other:______________

Please list the name of the other victims in the accident, if any:____

In your own words please describe the accident in detail: ____

____

____

INSURANCE INFORMATION

Your Auto Ins: _______________________ Policy #_________________ Claim#__________________ Phone#______________

Address:____

Other's Auto Ins:_____________________Policy #_________________ Claim#__________________ Phone#_______________

Address:____

MEDICAL INFORMATION

BEFORE THE ACCIDENT:

Have you had complaints in the involved area? ☐ Yes ☐ No Were they present at the time of the accident? ☐ Yes ☐ No

Describe: ____

Were you able to work without restrictions before the accident? ☐ Yes ☐ No

AT THE TIME OF THE ACCIDENT:

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that Day ☐ Next Day ☐ When? __________________

Did you go to a hospital or see any other doctor? ☐ Yes ☐ No When did you go? ☐ Immediately ☐ Next Day ☐ Other________

How did you get there? ☐ Ambulance ☐ Private Transportation Was medication prescribed? ☐ Yes ☐ No

Describe the treatment you received: ____

Name of hospital and/or attending doctor:____

Was he/she a: ☐ DDS ☐ MD ☐ DC ☐ DO Were any x-rays or other imaging obtained? ☐ Yes ☐ No

SINCE THE ACCIDENT:

Are your symptoms: ☐ Getting better ☐ Getting worse ☐ Staying the same

Have you been able to work since this injury? ☐ Yes ☐ No Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Did the police come to the scene of the accident? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

LEGAL INFORMATION

Were there any witnesses? ☐ Yes ☐ No Was a traffic violation issued? ☐ Yes ☐ No To whom? ______________________

Have you retained an attorney? ☐ Yes ☐ No If yes, whom? _______________________Phone:________________________

Patient/Guardian Signature:____ **Date:** _________________