# CHIROPRACTIC CARE CENTERS, S.C.

## CONFIDENTIAL PATIENT HEALTH COMPLAINT FORM

Name _____ Today's Date _____

Address _____ City _____ Zip _____

Home Phone (_____)_____ Work Phone (_____) _____ Cell Phone (____)_____

Email Address _____

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

S.S. # _____-_____-_____ Marital Status (circle one): Single / Married / Divorced / Widowed

Contact in Case of Emergency _____ Phone # (_____) _____

Who referred you to our office? _____

What is your chief complaint? _____

When did this complaint begin? (Date) _____

What caused this problem? _____

Complaints/Disturbances: ☐ come and go ☐ came on gradually ☐ came on suddenly

Symptoms are BETTER in: ☐ A.M. ☐ P.M. 6) Symptoms are WORSE in: ☐ A.M. ☐ P.M.

Symptoms have persisted for: ☐ hours ☐ 1-day ☐ days ☐ weeks ☐ months ☐ years

Symptoms developed from: ☐ a work injury ☐ an auto accident ☐ other accident

Explain what happened: _____

Describe other complaints. Please be specific:

Involving neck and head: _____

Involving mid-back/shoulders/arms & hands: _____

Involving low back/hips/legs & feet: _____

What activities make conditions WORSE? _____

What activities make conditions BETTER? _____

Have you ever had this condition/problem before? ☐ Yes ☐ No

If yes, when? _____

Indicate ability to perform the following activities: use codes U = unable P = painful L = limited N = normal

| | | |
|---|---|---|
| _____ coughing | _____ lying on back | _____ sleeping |
| _____ sneezing | _____ lying flat on stomach | _____ stooping |
| _____ bending forward | _____ lying on side with knees bent | _____ gripping |
| _____ turning over in bed | _____ climbing | _____ pushing |
| _____ walking short distances | _____ kneeling | _____ pulling |
| _____ standing more than one-hour | _____ balancing | _____ reaching |
| _____ sitting at a table | _____ dressing self | _____ sexual activity |

Company or Employer name? _____

What type of activities do you do at work? _____

What recreational or exercise activities are you involved in? _____

_____

Are you on a healthy diet? _____ Do you have any allergies? _____

Have you ever been treated by a chiropractor?_____ If yes, Doctor Name and Date_____

Do you have a medical doctor? ____ If yes, Doctor's name, date of last visit and location _____

_____

Purpose of that visit? _____ Last X-Rays from any doctor (Date)_____

Please list any surgeries you have had (include when and what they were for). _____

_____

Please list any medications that you are currently taking and what they are for (including any prescription medicines that you take as well as birth control pills and "over the counter" medications and pain relievers.)

_____

_____

Habits: ☐ Smoking Packs per Day ____ ☐ Alcohol Drinks per Day ____

☐ Coffee Cups per Day ____ ☐ Soda Cans per Day ____

## PAYMENT INFORMATION

Clinic policy requires that payment arrangements be made on the first visit if any balance is due. Our overall corporate policy is that finances do not become a barrier for you to get the care you need. Please indicate below how you will be taking care of this account:

☐ Health Insurance ☐ Cash/Check/Credit Card ☐ Auto Insurance

☐ Medicare ☐ Medicaid/Title 19 ☐ Worker's Compensation

Please give any insurance information you may have and a copy of your insurance card to our Front Desk Assistant. We will be happy to determine coverage for you.

## CONSENT TO TREAT

The primary treatment used by doctors of Chiropractic is the spinal adjustment. We will use primarily that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. By signing below you state that you are willing to undergo a chiropractic examination, x-rays of your spine (if indicated), and chiropractic treatment as outlined by the doctor after examination has been done.

Signature _____ Date _____

Consent to treat a minor child _____ Relation _____

**Family History:**

| | DIABETES | HEART | KIDNEY | CANCER | BACK | STROKE | HIGH B.P. |
|---|---|---|---|---|---|---|---|
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Women:** Are you pregnant? Yes No Unsure/Possibly

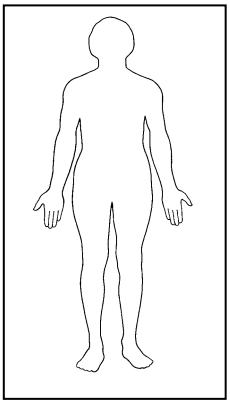
What was the first day of your last menstrual cycle? (Date) _____

**Shade and code areas to indicate location of pain or discomfort:**

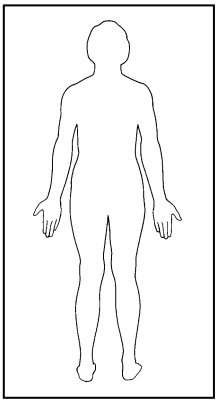
**Use Codes:**

| | |
|---|---|
| Numbness | - - - - - - - - - |
| Pins & Needles | + + + + + + |
| Burning | X X X X X X |
| Dull Ache | o o o o o o |
| Stabbing Pain | / / / / / / / / / |

FRONT



BACK



**Check any of the following diseases you have had:**

| | | | | |
|---|---|---|---|---|
| ☐AIDS | ☐Thyroid Disorder | ☐Chicken Pox | ☐Alcoholism | ☐Appendicitis |
| ☐Tuberculosis | ☐Diabetes | ☐STD | ☐Gall Stones | ☐Stroke |
| ☐Cancer | ☐Arthritis | ☐Fibromyalgia | ☐Anemia | ☐Heart Disease |
| ☐Epilepsy/Seizures | ☐Irritable Bowel Synd. | ☐Measles | ☐Goiter | ☐Mental Disorder |
| ☐Pneumonia | ☐Liver Disease | ☐Influenza | ☐Scoliosis | ☐Kidney Stones |
| ☐Psoriasis | ☐Pleurisy | ☐Eczema | ☐Mult.Sclerosis | ☐Eating Disorder |

## Check any of the following problems you have or have had in the past 6 months

Muscles & Joints
☐Low Back Pain
☐Pain Between Shoulders/ Mid-Back Pain
☐Neck Pain/Stiffness
☐Arm/Elbow/Wrist Pain
☐Walking Problems
☐Difficulty Chewing
☐Clicking Jaw
☐Leg/Knee/Foot Pain
☐Ankle Swelling
☐Hip Pain
☐Pain in Tailbone

Eye, Ear, Nose & Throat
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Earaches
☐Hearing Difficulty
☐Stuffed Nose
☐Ringing in Ears
☐Nose Bleeds
☐Sinus Trouble
☐Swollen Glands
☐Frequent Colds

General Problems
☐Fatigue
☐Night Sweats
☐Loss of Sleep
☐Fever
☐Headaches
☐Weakness
☐Migraines

Heart & Lungs
☐Wheezing
☐Chest Pain
☐Asthma
☐Short Breath
☐High Blood Pressure
☐Low Blood Pressure
☐Irregular Heart Beat
☐Heart Surgery
☐Lung Congestion
☐Coughing
☐Spitting Blood
☐Varicose Veins
☐Bronchitis

Stomach/Intestines
☐Poor Appetite
☐Excessive Appetite
☐Excessive Thirst
☐Nausea
☐Vomiting
☐Poor Digestion
☐Hemorrhoids/Piles
☐Liver Trouble
☐Gall Bladder
☐Weight Trouble
☐Stomach Cramps
☐Stomach Pain
☐Gas/Bloating
☐Heartburn
☐Black/Bloody Stool
☐Colitis
☐Diarrhea
☐Constipation

Men
☐Prostate Pain
☐Impotence
☐Infertility

Kidney/Bladder
☐Painful Urination
☐Excessive Urine
☐Discolored Urine
☐Bedwetting
☐Bad Urine Control

Women
☐Menses Irregular
☐Menstrual Cramps
☐Vaginal Pain
☐Breast Lumps
☐Pain During Sex
☐Infertility
☐Miscarriage

Nervous System
☐Nervousness
☐Numbness
☐Paralysis
☐Dizziness
☐Confusion
☐Depression
☐Fainting
☐Convulsions/Seizures
☐Cold Extremities