Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

Name_____Nickname_____Home Phone_____
Cell_____Carrier_____Email_____Social Security #_____
Contact Preference_____Home_____Cell_____Work_____Email_____Postal_____
Address:_____City_____State_____Zip_____
Age_____ Birth Date_____ Marital Status: S M W D Number of Children:_____

Who Referred you to this office_____

Your Employer_____ Occupation:_____ Work Phone:_____
Employer Address_____ City_____ State_____ Zip_____
Name of Spouse or Parent_____ Phone_____
Spouse Employed by_____ Work Phone_____

Emergency Contact_____ Phone_____

Language: English _____ Spanish _____ Indian _____ Japanese _____ Chinese_____ Korean _____ French_____
German _____ Russian _____ Other_____
Race: White _____ American Indian or Alaska Native _____ Asian _____ Native Hawaiin/Other Pacific Islander_____
Black or African American _____ Hispanic or Latino _____ Decline to Answer_____
Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Decline to Answer_____

Primary Insurance Company_____ Policy Holder Self / Spouse / Other _____
Secondary Insurance Company_____ Policy Holder Self / Spouse / Other _____
Is this an accident? Y or N If so, Date of Injury_____
( ) Auto Accident ( ) On the Job Injury have you reported this Y / N ( ) Other Attorney_____
How did you get injured?_____
List all complaints in order of severity
1._____ For how long _____ Is it getting worse Y or N
2._____ For how long _____ Is it getting worse Y or N
3._____ For how long _____ Is it getting worse Y or N
4._____ For how long _____ Is it getting worse Y or N
5._____ For how long _____ Is it getting worse Y or N
6._____ For how long _____ Is it getting worse Y or N
Doctors consulted for above complaints_____

Primary Care Physician_____
In order to coordinate the best health care would you like us to send a report to your Primary Care Physician: Yes / No

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Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature:_____

Patient Name_____Date_____

Medical History

Are you currently being treated for any conditions? _____Yes _____ No

Describe_____

Prior years illnesses_____

Past history of accident/trauma _____Motor Vehicle _____Industrial _____Other

Date of last Physical Exam_____ is there a chance that you are pregnant? _____Yes _____ No

Have you had X-rays/MRI/CT taken? _____ Yes _____ No If yes, where?_____

Are you taking any medications? Yes No (If yes, ask for form to fill out) Are you taking vitamins/Herbs/Minerals? Yes No

Do you have Allergies / Sensitivities? _____ Food _____ Environment _____ Medication

_____

_____

Have you been to a Chiropractor before? _____ Yes _____ No When_____

Explain_____

Have you ever:	**Yes**	**No**	**Briefly Explain**
Broken Bones?	_____	_____	_____
Been Hospitalized?	_____	_____	_____
Been in an Auto Accident?	_____	_____	_____
Had Sprains / Strains?	_____	_____	_____
Been struck unconscious?	_____	_____	_____
Had Surgery?	_____	_____	_____

Family History

Family Member Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc)

_____

_____

Stress Level	**Family**	**Severe**	**Moderate**	**Minimal**	**None**
	Job	_____	_____	_____	_____
	Other	_____	_____	_____	_____
	Explain Other	_____			

Are you nervous/anxious/depressed _____

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	**Never_____**	**Former_____**	**Current_____**	
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Soft Drinks	_____	_____	_____	_____
Water	_____	_____	_____	_____
Salty Foods	_____	_____	_____	_____
Sugary Foods	_____	_____	_____	_____
Artificial Sweeteners	_____	_____	_____	_____

What do you do to stay healthy: (eg) Exercise, Vitamins, etc._____

_____

_____

_____

_____

_____

	Yes	**No**
Do you experience pain everyday?	_____	_____
Do your symptoms interfere with daily life?	_____	_____
Does pain wake you up at night?	_____	_____
Are your symptoms worse during certain times of the days?	_____	_____
Do changes in weather affect your symptoms?	_____	_____
Do activities aggravate your symptoms?	_____	_____

What do you believe is wrong with you? _____

_____

_____

_____

_____

_____

Patient Name_____ **Date**_____

Cardiovascular	Current	Past
Poor circulation		
High Blood Pressure		
Aortic aneurism		
Heart disease		
Heart attack		
Chest pain		
High cholesterol		
Pace maker		
Irregular heartbeat		
Swelling of legs		
Anemia		
Varicose Veins		

Genitourinary	Current	Past
Kidney disease		
Lower side pain		
Burning urination		
Frequent urination		
Blood in urine		
Kidney stone		
Abdominal pain		

Hematologic / lymphatic	Current	Past
Hepatitis		
Blood clots		
Cancer		
Easy bruising		
Easy bleeding		
Fevers/chills/sweats		

Neurologic	Current	Past
Stroke		
Seizures/convulsions		
Head injury		
Brain aneurysm		
Numbness		
Severe headaches		
Pinched nerves		
Parkinson's disease		
Carpal tunnel		
Spinning/balance		
Fainting		

Respiratory	Current	Past
Asthma		
Tuberculosis		
Shortness of breath		
Emphysema		
Cold/flu		
Cough/wheezing		
Allergies		

Ear / Nose / Throat	Current	Past
Dizziness		
Hearing loss		
Sinus infection		
Nosebleed		
Sore throat		
Difficulty swallowing		
Bleeding gums		

Eyes	Current	Past
Glaucoma		
Double Vision		
Blurred Vision		

Integumentary	Current	Past
Skin ulcers		
Skin disease		
Eczema		
Psoriasis		
Rashes		

Psychiatric	Current	Past
Depression		
Anxiety Disorder		
Unusual stress		

Constitutional	Current	Past
Weight Loss / Gain		
Energy level problem		
Difficulty sleeping		

Allergic/Immunologic	Current	Past
Hives		
Immune disorder		
HIV / AIDS		
Allergy shots		
Cortisone use		
Visceral disorder		

Gastrointestinal	Current	Past
Gallbladder problems		
Constipation		
Liver problems		
Ulcers		
Diarrhea		
Nausea / vomiting		
Bloody stools		
Poor appetite		
Reflux		

Endocrine	Current	Past
Thyroid disease		
Diabetes		
Type I		
Type II		
Hair loss		
Menopausal		
Menstrual problems		

Head	Current	Past
Headaches		
Unusually frequent		
headaches		
Vertigo		
Light headedness		
Loss of smell		
Loss of taste		
Loss of balance		
Dizziness		
Unusually severe		
headaches		
Head feels heavy		

Neck	Current	Past
Pain in neck		
Neck feels out of place		
Muscle spasm in neck		
Jaw pain		
Grinding sounds in neck		
Popping sounds in neck		
Limited neck movement		
Neck pain with movement		
Swelling in neck		
Stiff neck		
Pinched nerve in neck		

Shoulders	Current	Past
Pain in shoulders		
Can't raise arm above		
shoulder level		
head		
Pain across shoulders		
Tension in shoulders		
Muscle spasm in shoulders		

Arms & Hands	Current	Past
Pain in upper arm		
Pain in hands		
Fingers go to sleep		
Pain in fingers		
Hands cold		
Sore joints in fingers		
Swollen joints in fingers		
Loss of grip strength		
Pain in elbow		
Pain in forearm		
Sensation of pins & needles		
in arms		
in fingers		

Mid Back	Current	Past
Mid back pain		
Pain from front to back		
Dull ache		
Pain over kidney area		
Muscle spasm in mid back		
Pain between shoulder blades		
Sharp stabbing pain		

Low Back	Current	Past
Low back pain		
Low back feels out of place		
Muscle spasms in low back		

Hips, Legs & Feet	Current	Past
Pain in buttocks		
Pain in feet		
Pain in ankles		
Pain in toes		
Arthritis		
Leg cramps		
Cold feet		
Numbness in leg		
Swollen ankles		
Numbness in toes		
Swollen feet		
Pain down legs		
Knee pain		
Pins and needles in legs		
Spinal curvature		
Disc problems		
Gout		

General	Current	Past
Poor posture		
Bursitis		
Swelling		
Numbness		
Cancer		

Other_____

_____

_____

_____

_____

Suiter Chiropractic Clinic, LLC
636-227-4378

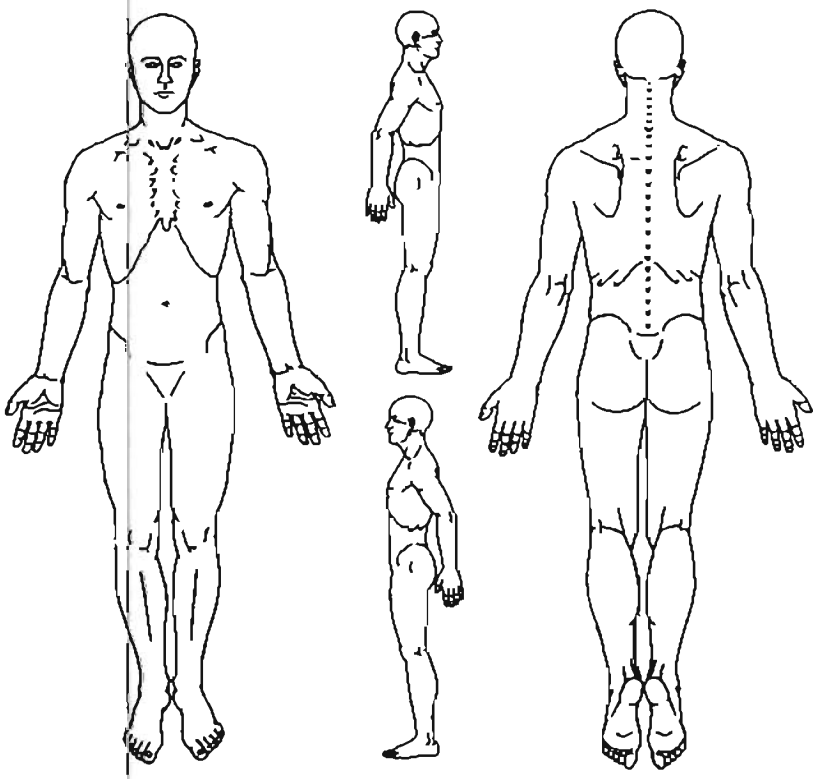
INITIAL _____

Dr. Leonard Suiter

Patient Name _____ Date _____

On the picture below, please use the following letters to indicate TYPE and LOCATION of the pain you currently are experiencing.

A= Ache	B= Burning	N= Numbness
O= Other	P= Pins & Needles	S= Stabbing / Sharp



Complaints	No Pain			Moderate Pain						Severe Pain	
1_____	0	1	2	3	4	5	6	7	8	9	10
2_____	0	1	2	3	4	5	6	7	8	9	10
3_____	0	1	2	3	4	5	6	7	8	9	10
4_____	0	1	2	3	4	5	6	7	8	9	10
5_____	0	1	2	3	4	5	6	7	8	9	10

Suiter Chiropractic Clinic, LLC
15320 Manchester Road
Ellisville, MO 63011
636-227-4378

MEDICATIONS

Name	Strength	Dosage	Frequency	Duration	Refills Available	Prescribed By
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Patient Name: _____

Date: _____

INITIAL:_____