

# HEALTH HISTORY

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

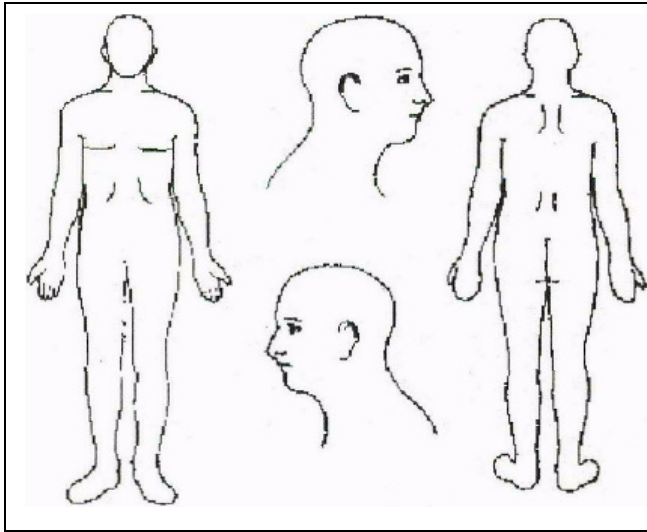
What brought you here today? \_\_\_\_\_

Symptoms developed from: Sports Injury    Auto Accident    Work Injury    Other \_\_\_\_\_

When did they begin? \_\_\_\_\_ How did it occur? \_\_\_\_\_

Place an "X" on areas of pain and a letter describing it.

A = Ache    B = Burning    T = Tingling  
N = Numbness    S = Sharp    ST = Shooting



Do you experience:

Nausea or visual disturbances?    Y    N  
Numbness in feet or legs?    Y    N  
Pain or cracking in jaw?    Y    N  
Changes in bowel or bladder function?    Y    N

## PAIN SCALE

Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

NONE    LITTLE    MEDIUM    SEVERE

	Better	Worse	Same
Ice			
Heat			
Sitting			
Standing			
Walking			
Lying down			
Cough/sneeze			
Sleeping			
In the morning			
At night			
Other:			

Numbness in hands?    Y    N  
Abnormal blood pressure?    Y    N

## PAST MEDICAL HISTORY

Have you experienced this problem before?    Y    N    When? \_\_\_\_\_

Have you seen another provider for it? MD    PT    Acup \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Diagnosis? \_\_\_\_\_ Treatment? \_\_\_\_\_ Outcome? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Address? \_\_\_\_\_

Have you seen a Doctor of Chiropractic before?    Y    N    When? \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Surgeries/Hospitalizations? When? \_\_\_\_\_

Major Illnesses \_\_\_\_\_

Medications/Supplements(circle)    None    Anti-inflammatory    High cholesterol meds    Anti-depressants

Osteoporotic meds    Steroids    Pain meds    High blood pressure    Multivitamin    Fish oils

Other: \_\_\_\_\_

## SOCIAL HEALTH

Do you smoke?    Y    N    \_\_\_\_\_ packs/day

Consume caffeine?    Y    N    \_\_\_\_\_ cups/day

Consume alcohol?    Y    N    \_\_\_\_\_ glasses/week

Exercise?    Y    N    \_\_\_\_\_ x/week

## YOUR PAST HISTORY

Circle any conditions you now have or had in past.

Diabetes    Cancer    Heart Disease    # pregnancies \_\_\_\_\_

Arthritis    High Blood Pressure    Osteoporosis

Incontinence    Other \_\_\_\_\_

Is there any other information that you think would be helpful? \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE TURN OVER TO COMPLETE FORM

# Patient Information Sheet

## PATIENT:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Gender: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS# \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone (H) # \_\_\_\_\_ (W) # \_\_\_\_\_ (C) # \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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## GUARDIAN (if under 18 years of age):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

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## EMERGENCY: Name and address of nearest relative or friend not living with you:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Phone (H) # \_\_\_\_\_ (W) # \_\_\_\_\_ (C) # \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

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## PAYMENT METHOD: Cash Check Credit/Debt card

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## INSURANCE: Do not fill out if we photocopied your card.

You are ultimately responsible for the balance of which your benefits do not cover.

**Personal**  **Auto**  **Workers Compensation**

Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group or Claim #(Auto): \_\_\_\_\_

Ins Adjuster's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Workers Compensation: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ ID/Policy # \_\_\_\_\_

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## RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for the bill.

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H) # \_\_\_\_\_ (W) # \_\_\_\_\_ (C) # \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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## SIGNATURE: (Patient, Parent, Legal Guardian, or Responsible Party)

I request services X \_\_\_\_\_