

PAST HEALTH HISTORY (CON'T)

SURGERIES:

I DENY ANY SURGERY (IES)

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> ANGIOPLASTY | <input type="checkbox"/> CORONARY ARTERY BYPASS | <input type="checkbox"/> HEMORRHOIDECTOMY | <input type="checkbox"/> LAMINECTOMY | <input type="checkbox"/> TONSILLECTOMY |
| <input type="checkbox"/> APPENDECTOMY | <input type="checkbox"/> COSMETIC | <input type="checkbox"/> HERNIA REPAIR | <input type="checkbox"/> MASTECTOMY | <input type="checkbox"/> OTHER (PLEASE BE SPECIFIC): _____ |
| <input type="checkbox"/> CAESAREAN SECTION | <input type="checkbox"/> D & C | <input type="checkbox"/> HYSTERECTOMY | <input type="checkbox"/> PACEMAKER INSERTION | _____ |
| <input type="checkbox"/> CARDIAC CATHETERIZATION | <input type="checkbox"/> DENTAL SURGERY | <input type="checkbox"/> JOINT RECONSTRUCTION | <input type="checkbox"/> ROTATOR CUFF | _____ |
| <input type="checkbox"/> CARPAL TUNNEL REPAIR | <input type="checkbox"/> GALL BLADDER | <input type="checkbox"/> JOINT REPLACEMENT | <input type="checkbox"/> SPINAL FUSION | |

OB/GYN:

I DENY ANY OB/GYN ISSUE(S)

- I HAVE NEVER BEEN PREGNANT
 I HAVE BEEN PREGNANT IN THE PAST
 I AM CURRENTLY PREGNANT

MENSTRUAL HISTORY:

- MY MENSES IS REGULAR
 MY MENSES IS IRREGULAR
 I AM CURRENTLY IN MENOPAUSE
- AGE OF ONSET _____ DATE OF LAST MENSES ____/____/____

INJURIES:

I DENY ANY INJURY (IES)

- | | | | |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> BACK INJURY | <input type="checkbox"/> FRACTURE | <input type="checkbox"/> INDUSTRIAL ACCIDENT | <input type="checkbox"/> MOTOR VEHICLE ACCIDENT |
| <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> DISABILITY | <input type="checkbox"/> JOINT INJURY | <input type="checkbox"/> MILD/MODERATE SOFT TISSUE INJURY |
| <input type="checkbox"/> SEVERE FALL | <input type="checkbox"/> HEAD INJURY | <input type="checkbox"/> SEVERE LACERATION | <input type="checkbox"/> SEVERE SOFT TISSUE INJURY |

IMMUNIZATIONS:

I DENY ANY IMMUNIZATION(S)

- | | | | | | |
|---|--|--|---|------------------------------------|---|
| <input type="checkbox"/> DTaP (DIPHTHERIA, TETANUS & PERTUSSIS) | <input type="checkbox"/> FLU | <input type="checkbox"/> HEPATITIS C | <input type="checkbox"/> MMR (MEASLES, MUMPS & RUBELLA) | <input type="checkbox"/> SMALL POX | <input type="checkbox"/> WHUPPING COUGH (PERTUSSIS) |
| <input type="checkbox"/> HEPATITIS A | <input type="checkbox"/> HEPATITIS B | <input type="checkbox"/> INFLUENZA | <input type="checkbox"/> PNEUMOCOCCAL | <input type="checkbox"/> TB | |
| <input type="checkbox"/> IPV (POLIO) | <input type="checkbox"/> PPD (MANTOUX TEST-TB) | <input type="checkbox"/> VARIVAX (CHICKEN POX) | | | |

NON-DRUG ALLERGIES:

I DENY ANY NON-DRUG ALLERGIES

- | | | | | | |
|----------------------------------|--------------------------------|-------------------------------|--|-------------------------------|---------------------------------|
| <input type="checkbox"/> ANIMALS | <input type="checkbox"/> DAIRY | <input type="checkbox"/> EGGS | <input type="checkbox"/> FOOD COLORING | <input type="checkbox"/> MOLD | <input type="checkbox"/> POLLEN |
|----------------------------------|--------------------------------|-------------------------------|--|-------------------------------|---------------------------------|

PREVIOUS TREATMENT

PREVIOUS CHIROPRACTIC CARE? YES IF YES, WHO? (NAME)
 NO

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? YES IF YES, WHO? (NAME)
 NO

LOCATION OF OFFICE:

TYPE OF TREATMENT:

WERE YOU SATISFIED WITH THE RESULTS OF YOUR TREATMENT? YES EXPLAIN:
 NO

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS? YES IF YES, PLEASE MARK OR LIST (BE SPECIFIC). ALLERGY MEDICATION BLOOD PRESSURE MEDS. MUSCLE RELAXERS PAIN KILLERS (PLEASE SPECIFY)
 NO ANTI-DEPRESSANTS INSULIN NERVE PILLS OTHER

DO YOU WEAR ANY OF THE FOLLOWING? HEAL LIFTS ARCH SUPPORTS INNER SOLES ORTHOTICS PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT - EVEN IF UNRELATED:

FAMILY HISTORY - ENTER INITIALS BELOW: A = ALIVE D = DECEASED

_____ GENERAL FAMILY _____ MOTHER _____ PATERNAL GRANDMOTHER _____ MATERNAL GRANDMOTHER _____ DAUGHTER(S) _____ SISTER(S)
 _____ FATHER _____ PATERNAL GRANDFATHER _____ MATERNAL GRANDFATHER _____ SON(S) _____ BROTHER(S)

NAME

RELATION

PAST & PRESENT HEALTH PROBLEMS

SOCIAL HISTORY

ALCOHOL: NEVER WEEKLY SOCIAL BEER WINE OZ.'S # GLASSES LIQUOR DAILY MONTHLY CONSUMPTION ONLY **DIET:** HIGH FAT HIGH PROTEIN LOW CALORIE LOW FIBER LOW HIGH FIBER HIGH SALT LOW CARB LOW SALT SUGAR
Mark all that apply.

DRUGS: DENY ANY ILLEGAL DRUG USE HAVE NOT USED DRUGS SINCE _____ DENY USE OF IV DRUGS HAVE USED DRUGS FOR _____ **TOBACCO:** DENY TOBACCO USE QUIT # PER: DAY MONTH # CHEW LIVE W/A SMOKER SMOKING _____ WEEK

PLEASE READ CAREFULLY AND SIGN BELOW:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic 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 Chiropractic Clinic will be credited to my account upon 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 or 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 or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the x-rays are for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office. I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE:
 (SIGNATURE INDICATES CONSENT TO TREAT)

DATE:

PATIENT (PRINT NAME):

PATIENT'S SIGNATURE:

DATE:

X