

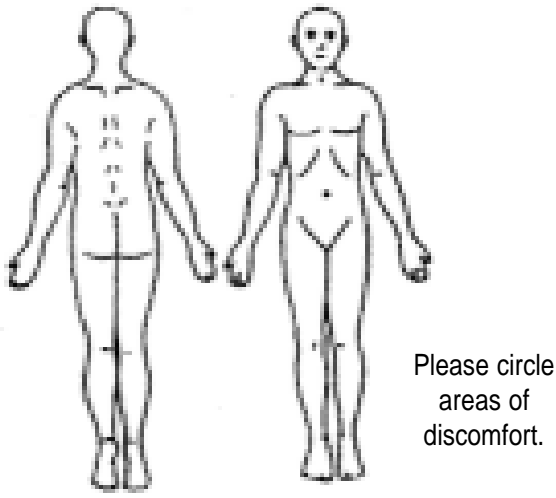


NAME:		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:	TODAYS DATE:		DATE OF BIRTH:	
ADDRESS:		CITY:		STATE:		ZIP:	
HOME PHONE:		CELL:		FAX:			
SOCIAL SECURITY #:		DRIVER'S LICENSE #:		STATE:		E-MAIL ADDRESS:	
SPOUSES NAME:		AGES OF CHILDREN:		OCCUPATION/JOB TITLE:			
EMPLOYER/BUSINESS NAME:		BUSINESS ADDRESS:					
BUSINESS PHONE:		TYPE OF WORK:					
HOW DID YOU HEAR ABOUT US?							

EMERGENCY CONTACT:	PHONE #:
ADDRESS:	RELATIONSHIP:

INSURANCE	WHO IS RESPONSIBLE FOR YOUR BILL? <input type="checkbox"/> SELF <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> MEDICAID <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> MEDICARE <input type="checkbox"/> OTHER (BE SPECIFIC):	HEALTH ID CARD #:
	PERSONAL HEALTH INSURANCE CARRIER:	GROUP #:
	INSURED PERSON'S NAME:	PRIMARY CARE PHYSICIAN:
	INSURED PERSON'S DATE OF BIRTH:	PHARMACY:
	INSURED PERSON'S SOCIAL SECURITY #:	

CURRENT HEALTH CONDITION

 <p>Please circle areas of discomfort.</p>	CHIEF COMPLAINT: (WHY ARE YOU HERE TODAY?)

BODY AREA INVOLVED:	<input type="checkbox"/> CERVICAL (NECK) <input type="checkbox"/> SPINE (MID-BACK), RIBS, PELVIS (LOW BACK)	<input type="checkbox"/> UPPER EXTREMITY (ARMS, WRIST, HANDS) <input type="checkbox"/> LOWER EXTREMITY (LEGS, FEET, TOES)
CONDITION:	<input type="checkbox"/> NEW <input type="checkbox"/> RECURRING	<input type="checkbox"/> EXACERBATION <input type="checkbox"/> CHRONIC
MECHANISM OF ONSET:	<input type="checkbox"/> AUTO <input type="checkbox"/> WORK	<input type="checkbox"/> FALL <input type="checkbox"/> LIFTING <input type="checkbox"/> OVER EXERTION <input type="checkbox"/> REPETITIVE MOTION <input type="checkbox"/> UNKNOWN <input type="checkbox"/> SLEPT WRONG <input type="checkbox"/> SLIP OR FALL <input type="checkbox"/> NO INJURY <input type="checkbox"/> OTHER
SYMPTOMS:	<input type="checkbox"/> PAIN <input type="checkbox"/> NUMBNESS	<input type="checkbox"/> STIFFNESS <input type="checkbox"/> WEAKNESS
LOCATION:	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	<input type="checkbox"/> BILATERAL
QUALITY SHOOTING:	<input type="checkbox"/> BURNING <input type="checkbox"/> DIFFUSE	<input type="checkbox"/> DULL/ACHING <input type="checkbox"/> LOCALIZED <input type="checkbox"/> SHARP <input type="checkbox"/> SHOOTING <input type="checkbox"/> STABBING <input type="checkbox"/> THROBBING <input type="checkbox"/> TIGHTNESS <input type="checkbox"/> TINGLING <input type="checkbox"/> RADIATING <input type="checkbox"/> OTHER

Below is a list of diseases that may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYMPTOMS - Please fill out all of the sections, even if "DENY"

CONSTITUTIONAL: I DENY ANY CONSTITUTIONAL ISSUE(S) CHILLS WEIGHT GAIN WEIGHT LOSS FATIGUE NIGHT SWEATS DAYTIME SOMNOLENCE (DROWSINESS) FEVER

EYE/VISION: I DENY ANY EYES/VISION ISSUE(S) BLINDNESS EYE PAIN TEARING FIELD CUTS (VISUAL FIELD DEFECT) CATARACTS CHANGE IN VISION WEAR GLASSES AND/OR DOUBLE VISION PHOTOPHOBIA BLURRED VISION GLAUCOMA ITCHING (AROUND EYES) CONTACT LENSES

EARS, NOSE AND THROAT: I DENY ANY E/N/T ISSUE(S) BLEEDING FAINTING NASAL CONGESTION EAR DRAINAGE POST NASAL DRIP HOARSENESS DISCHARGE HEADACHES SINUS INFECTIONS EAR INFECTION(S) DIFFICULTY SWALLOWING RHINORRHEA (RUNNY NOSE) DIZZINESS LOSS OF SMELL DENTAL IMPLANTS HEARING LOSS EAR PAIN SINUS INFECTIONS SNORING SORE THROATS (FREQUENT) TINNITUS (RINGING IN EARS) TMJ PROBLEMS

RESPIRATION: I DENY ANY RESPIRATORY ISSUE(S) ASTHMA COUGHING UP BLOOD SPUTUM PRODUCTION COUGH SHORTNESS OF BREATH WHEEZING

CARDIOVASCULAR: I DENY ANY CARDIOVASCULAR ISSUE(S) ANGINA (CHEST PAIN OR DISCOMFORT) HEART MURMUR PALPITATIONS (IRREGULAR OR FORCEFUL BEATING OF THE HEART) SWELLING OF LEGS CHEST PAIN HEART PROBLEMS PAROXYSMAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH) ULCERS CLAUDICATION (LEG PAIN OR ACHINESS) ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN) VARICOSE VEINS

GASTROINTESTINAL: I DENY ANY GASTROINTESTINAL ISSUE(S) ABDOMINAL PAIN DIARRHEA INDIGESTION ABNORMAL STOOL CALIBER (QUALITY) BELCHING DIFFICULTY SWALLOWING JAUNDICE (YELLOWING OF SKIN) ABNORMAL STOOL COLOR VOMITING BLACK, TARRY STOOLS HEARTBURN NAUSEA ABNORMAL STOOL CONSISTENCY BLOOD CONSTIPATION HEMORRHOIDS RECTAL BLEEDING VOMITING

FEMALE: I DENY ANY FEMALE ISSUE(S) BIRTH CONTROL THERAPY CRAMPS IRREGULAR MENSTRUATION VAGINAL DISCHARGE BREAST LUMP/PAIN FREQUENT URINATION URINE RETENTION BURNING URINATION HORMONE THERAPY VAGINAL BLEEDING

MALE: I DENY ANY MALE ISSUE(S) BURNING URINATION ERECTILE DYSFUNCTION FREQUENT URINATION HESITANCY/DRIBBLING PROSTATE PROBLEMS URINATION RETENTION

ENDOCRINE: I DENY ANY ENDOCRINE ISSUE(S) COLD INTOLERANCE EXCESSIVE APPETITE EXCESSIVE THIRST GOITER HEAT INTOLERANCE VOICE CHANGES DIABETES EXCESSIVE HUNGER FREQUENT URINATION HAIR LOSS UNUSUAL HAIR GROWTH

SKIN: I DENY ANY SKIN ISSUE(S) CHANGES IN NAIL TEXTURE HAIR GROWTH HIVES PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING) RASH SKIN LESIONS/ULCERS CHANGES IN SKIN COLOR HAIR LOSS ITCHING HISTORY OF SKIN DISORDERS VARICOSITIES

NERVOUS SYSTEM: I DENY ANY NERVOUS SYSTEM ISSUE(S) DIZZINESS HEADACHES LOSS OF CONSCIOUSNESS NUMBNESS SLEEP DISTURBANCE STROKES UNSTEADINESS FACIAL WEAKNESS LIMB WEAKNESS LOSS OF MEMORY SEIZURES STRESS TREMORS OF GAIT

PSYCHOLOGIC: I DENY ANY PSYCHOLOGIC SYSTEM ISSUE(S) ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE) ANXIETY BEHAVIORAL CHANGE(S) CONFUSION DEPRESSION MEMORY LOSS APPETITE CHANGES BIPOLAR DISORDER CONVULSIONS INSOMNIA MOOD CHANGE(S)

ALLERGY: I DENY ANY ALLERGY ISSUE(S) ANAPHYLAXIS (HISTORY OF SNEEZING) FOOD INTOLERANCE ITCHING NASAL CONGESTION SNEEZING

HEMATOLOGY: I DENY ANY HEMATOLOGIC ISSUE(S) ANEMIA BLOOD CLOTTING BRUISES EASILY LYMPH NODE SWELLING BLEEDING BLOOD TRANSFUSION(S) FATIGUE

PAST HEALTH HISTORY - Please fill out carefully as these problems can affect your overall course of care.

CHILDHOOD ILLNESS: I DENY ANY CHILDHOOD ILLNESS(ES) ADD BED WETTING DIABETES FOOD ALLERGIES MEASLES SEIZURE DISORDER ALLERGIES/HAYFEVER CEREBRAL PALSY EAR INFECTIONS HEADACHES MUMPS SICKLE CELL ANEMIA ASTHMA CHICKEN POX FETAL DRUG EXPOSURE HEPATITIS RASH SPINA BIFIDA ATOPIC DERMATITIS (ECZEMA) DEPRESSION EXPOSURE HIV SCOLIOSIS OTHER (PLEASE DESCRIBE)

ADULT ILLNESS: I DENY ANY ADULT ILLNESS(ES) ALZHEIMERS CVA (STROKE) FIBROMYALGIA LUPUS ERYTHEMA (DISCOID) SEIZURE DISORDER ANEMIA CYSTIC KIDNEY DISEASE HEART DISEASE LUPUS ERYTHEMA (SYSTEMIC) SHINGLES ARTHRITIS DEPRESSION HEPATITIS MULTIPLE SCLEROSIS STD'S (UNSPECIFIED) ASTHMA DIABETES (INSULIN) HIV PARKINSON'S DISEASE SUICIDE ATTEMPT(S) CANCER DIABETES (NON INSULIN) HYPERTENSION PLEURISY THYROID PROBLEMS CHICKEN POX EAR INFECTIONS (FREQUENT) INFLUENZAL PNEUMONIA PNEUMONIA VERTIGO CROHN'S/COLITIS EMPHYSEMA LIVER DISEASE PSYCHIATRIC PROBLEMS PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION CRPS (RSD) EYE PROBLEMS LUNG DISEASE SCOLIOSIS OTHER _____

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

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 ALLERGY MEDICATION BLOOD PRESSURE MEDS. MUSCLE RELAXERS PAIN KILLERS (PLEASE SPECIFY)
 NO OR LIST (BE SPECIFIC). 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 SUGAR HIGH FIBER HIGH SALT LOW CARB LOW SALT

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: X
	DATE: