

Patient Health History

Date	I.D. #
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Name: _____ Age: _____ Date of Birth: _____ Sex: MF
Address: _____ City: _____ State: _____ Zip: _____
Phone (Home): _____ (Work): _____ Marital Status: S M D W # of Children: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Driver's License Number: _____
Spouse's Name: _____ Spouse's Age: _____ Spouse's Date of Birth: _____
Spouse's Occupation: _____ Spouse's Social Security Number: _____
Spouse's Employer: _____ Spouse's Phone (Work): _____
Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____
Insurance Company: _____ Spouse's Insurance Company: _____
How did you hear about this office: _____ Referred by: _____
Past Chiropractic Care: Yes No When? _____ Doctor's Name: _____ Results: _____

Are your present problems due to an injury? Yes No On Job Auto Accident Personal Injury Other: _____
Has the accident been reported? Yes No To Employer Auto Carrier Other: _____
Are you now or have you ever been disabled? (Service or Work)? Yes No When? _____
Have you retained an attorney? Yes No Name & Address: _____

What is your current work status?

Full time, no restrictions Full time, restrictions Full time Homemaker Full time student
Part time, no restrictions Part time, restrictions Retired Unemployed
Off work due to restrictions Other _____

Restrictions:

Off work: Yes No Previously From: _____ to _____
Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____
Do/did you require outside help at home?
Yes No (If yes, what help do/did you need?) _____

List any accidents or falls and dates: Auto: _____ Recreation: _____
Sports: _____ Work Related: _____ Other: _____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? Yes No Why? _____
Were you ever knocked unconscious? Yes No (If yes, please explain): _____
Have you ever had X-rays taken? Yes No When? _____ By Whom? _____
For what ailments were these X-rays made? _____
Do you wear orthotics or heel lifts? Yes No Fitted by whom? _____ When? _____
Do you suffer from any condition other than that for which you are now consulting us? Yes No _____
Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?
(Please list) _____

OPERATIONS AND PROCEDURES

I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
Other	_____				

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. Never Previously Presently

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td>GENERAL SYMPTOMS</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Allergy(What) _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Bronchitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Chills (Constant)</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Convulsions</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Dizziness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Fainting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Fatigue</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 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DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles
<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV Positive

HABITS	EXERCISE	FAMILY HISTORY
<input type="checkbox"/> Smoking Packs/day: _____	<input type="checkbox"/> None	Diabetes <input type="checkbox"/> Kidney <input type="checkbox"/> Cancer <input type="checkbox"/> Back <input type="checkbox"/>
<input type="checkbox"/> Drinking Alcohol: (Cups/day) _____	<input type="checkbox"/> Moderate	Mother <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Coffee Cups/Day: _____	<input type="checkbox"/> Daily	Father <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Soft Drink Bottles or Cans/Day: _____	Type: _____	Brother(s), # of _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Water Cups/Day: _____	_____	Sister(s), # of _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider **will/will not** prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/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 amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____