Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance card(s).
All information you supply is confidential. We comply with all federal privacy standards.

Name_____ Home Phone_____

Address_____ Work Phone_____

City, State, Zip_____ Cell Phone_____

Birth date_____ Age_____ E-mail Address_____

SS# xxx-xx-_____ Primary Doctor (Full Name & Facility) _____

Would you like us to send your family doctor a copy of your chiropractic health records? □ Yes □ No

Occupation_____ Employer_____

Marital Status: M W Sep. D Sin Spouse Name_____ No. of Children_____

Contact in case of emergency_____ Phone #_____

Preferred method of contact: □ Text Message □ Email □ Cell Phone □ Home Phone

How did you hear about our office? _____

Spinal health is especially important when you are pregnant. Is there any chance that you are pregnant? **Y N**

Auto & work injuries can cause serious spinal problems. Is this visit related to an auto accident or work injury? **Y N**
Date and description of injury: _____

PLEASE COMPLETE ALL OF THE FOLLOWING SECTIONS TO THE BEST OF YOUR ABILITY!

What is your MAJOR COMPLAINT: _____

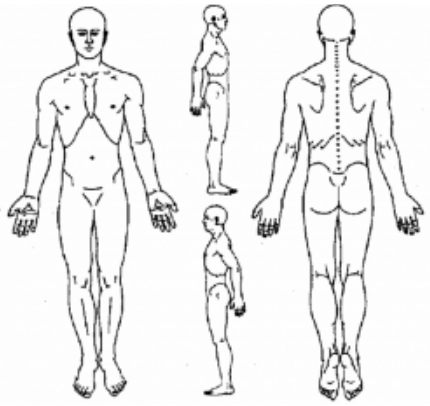
Does the pain travel down your arms or legs? Y N
□ Shoulder □ Arm □ Hand □ Buttocks □ Legs □ Feet

What do you think caused your symptoms? _____
_____

When did the symptoms start? _____

Rate Your Current Pain: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe
Rate Your Pain at its Worst: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe

(Please mark on the diagram exactly where you are experiencing pain)



How often are you experiencing symptoms?
□ Occasional (25% or less) □ Intermittent (26-50%) □ Frequent (51-75%) □ Constant (76-100%)

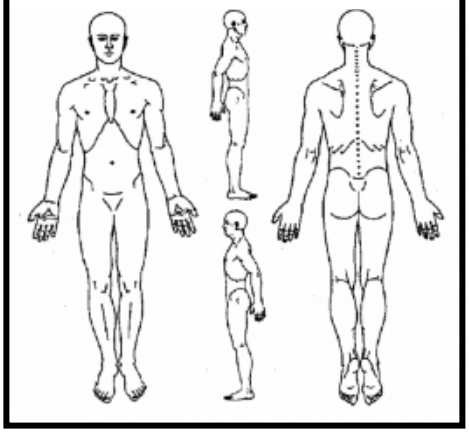
How would you describe the symptoms you are currently feeling? (Check all that apply):
□ Achy □ Burning □ Catching □ Cramps □ Dull □ Nagging □ Numbness □ Pinching □ Sharp
□ Shooting □ Sore □ Stabbing □ Stiffness □ Tight □ Tingling □ Tired/Weak □ Throbbing

What makes your symptoms WORSE? (Check all that apply):
□ Nothing □ Bending □ Cough/Sneeze □ Inactivity □ Lifting □ Lying down □ Movement/exercise
□ Reaching □ Sitting □ Standing □ Twist/ Turn □ Walking □ Morning □ Midday □ Evening
□ Other: _____

What makes your symptoms BETTER? (Check all that apply):
□ Nothing □ Heat □ Ice □ Inactivity/Rest □ Lying Down □ Movement/exercise □ Pain medication □ Sitting
□ Standing □ Stretching □ Walking □ Morning □ Midday □ Evening □ Other:_____

What is your SECONDARY COMPLAINT: _____

(Please mark on the diagram exactly where you are experiencing pain)



Does the pain travel down your arms or legs? **Y** **N**
□ Shoulder □ Arm □ Hand □ Buttocks □ Legs □ Feet

What do you think caused your symptoms? _____
_____

When did the symptoms start? _____

Rate Your Current Pain: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe
Rate Your Pain at its Worst: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe

How often are you experiencing symptoms?
□ Occasional (25% or less) □ Intermittent (26-50%) □ Frequent (51-75%) □ Constant (76-100%)

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□ Shooting □ Sore □ Stabbing □ Stiffness □ Tight □ Tingling □ Tired/Weak □ Throbbing

What makes your symptoms WORSE? (Check all that apply):
□ Nothing □ Bending □ Cough/Sneeze □ Inactivity □ Lifting □ Lying down □ Movement/exercise
□ Reaching □ Sitting □ Standing □ Twist/ Turn □ Walking □ Morning □ Midday □ Evening
□ Other: _____

What makes your symptoms BETTER? (Check all that apply):
□ Nothing □ Heat □ Ice □ Inactivity/Rest □ Lying Down □ Movement/exercise □ Pain medication □ Sitting
□ Standing □ Stretching □ Walking □ Morning □ Midday □ Evening □ Other:_____

PLEASE COMPLETE ALL OF THE FOLLOWING SECTIONS TO THE BEST OF YOUR ABILITY

How serious are you to correcting this health challenge? □ Not Serious □ Somewhat Serious □ Very Serious

In addition to your major and secondary complaints, are you experiencing any of the following symptoms?
(Even if you don't think they are related to chiropractic):
□ Headaches □ Vertigo □ Neck Pain □ Shoulder/Arm Pain □ Constipation □ Sciatica □ Hip Pain □ Knee Pain
□ Plantar Fasciitis □ Neuropathy □ Carpal Tunnel Syndrome □ Other: _____

Of the above mentioned health concerns, please list in order of importance (from most to least painful):
1. _____ 2. _____ 3. _____ 4. _____

Have you had Spinal Surgery: Y N **When (approx.)**:_____
Do you have any permanent hardware as a result of surgery? Y N

Please list all surgeries you have had: _____
_____

Do you feel the pain you are experiencing is normal? **YES** **NO**

What do you feel is preventing you from getting better? _____

What ONE word best describes how this pain or inability to complete simple tasks makes you feel?
□ Frustrated □ Aggravated □ Discouraged □ Hopeless □ Anxious □ Depressed □ Annoyed
□Other: _____

What is your stress level? □ NO stress □ Minimal stress □ Moderate stress □ Greatly stressed

How much sleep do you average per night? _____Hours
Sleep Position: □ Stomach □ Back □ Left Side □ Right Side

List the 4 most traumatic injuries you have had throughout your lifetime:

1. _____
2. _____
3. _____
4. _____

Activities of Daily Living -- How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	□	□	□	□	Grocery shopping	□	□	□	□
Rising out of chair	□	□	□	□	Household chores	□	□	□	□
Standing	□	□	□	□	Lifting objects	□	□	□	□
Walking	□	□	□	□	Reaching overhead	□	□	□	□
Lying down	□	□	□	□	Showering or bathing	□	□	□	□
Bending over	□	□	□	□	Dressing myself	□	□	□	□
Climbing stairs	□	□	□	□	Physical Relationship	□	□	□	□
Using a computer	□	□	□	□	Getting to sleep	□	□	□	□
Getting in/out of car	□	□	□	□	Staying asleep	□	□	□	□
Driving a car	□	□	□	□	Concentrating	□	□	□	□
Looking over shoulder	□	□	□	□	Exercising	□	□	□	□
Caring for family	□	□	□	□	Yard work/Gardening	□	□	□	□
Occupation	□	□	□	□	Using the restroom	□	□	□	□
Hobbies	□	□	□	□	Twisting/Turning	□	□	□	□

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or back? **Y N**

When was your last complete spinal examination including X-rays? _____

Describe your typical eating habits:
□ Skip breakfast □ Two meals a day □ Three meals a day
□ Snacking between meals □ Late night binging □ Hungry all the time

How would you rate your eating habits?: □ Excellent □ Good □ Fair □ Poor

How much water do you drink on a daily basis? _____ Soft drinks? _____ Coffee? _____

Do you exercise? Y N How often? _____Type:_____

Do you smoke? Y N How often? _____

Do you drink alcohol? Y N How often? _____

Current Medications/Nutritional Supplements: List ANY/ALL medications/nutritional supplements you are CURRENTLY taking. Be Specific.

Medication/Nutritional Supplement	Dosage	For What Condition?	How long have you been taking this?

Review of Symptoms-- YOU MUST COMPLETE ALL OF THE FOLLOWING SECTIONS!!

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please indicate with a (C) **Conditions you have now** or with a (P) the **conditions you have had in the past.**

a. Musculoskeletal

___ Osteoporosis ___Arthritis ___Scoliosis ___Neck pain ___Back Pain ___Hip disorders
___ Knee injuries ___Foot/ankle pain ___ Shoulder pain ___Elbow/wrist pain ___TMJ issues ___Poor posture
___Broken/Fractured bones ___Fibromyalgia ___Spinal Degeneration ___Spinal Disc Problems

b. Nervous System

___Facial weakness ___Limb weakness ___Loss of consciousness ___Seizures ___Slurred speech ___Stress ___Tremors
___Unsteadiness of gait/loss of balance ___Headaches ___Dizziness ___Pins/Needles ___Numbness ___ Epilepsy
___Trouble concentrating ___Tingling ____Multiple Sclerosis

c. Cardiovascular

___High blood pressure ___Low Blood pressure ___High cholesterol ___Poor circulation ___Angina ___Excessive bruising
___Chest pain ___Claudication (leg pain/ache) ___Heart murmur ___Heart problems ___Orthopnea (difficulty breathing lying down)
___Palpitations ___Paroxysmal nocturnal dyspnea (waking at night with shortness of breath) ___Swelling of legs ___Varicose veins
___Stroke ___Arteriosclerosis ___Rheumatic fever

d. Respiratory

___Asthma ___Apnea ___Emphysema ___Cough ___Wheezing ___Hay fever ___Shortness of breath ___Pneumonia
___Tuberculosis ___Sleep Apnea

e. Gastrointestinal/Digestion

___Anorexia or bulimia ___Ulcer ___Food sensitivity ___Heartburn ___Constipation ___Diarrhea ___Abdominal pain
___Belching ___Black-tarry stool ___Difficulty swallowing ___Hemorrhoids ___Indigestion ___Jaundice ___Nausea
___Rectal bleeding ___Abnormal stool color/consistency ____ Blood in stool ___Vomiting ___Vomiting blood
___Gallbladder trouble ___Diverticulitis ___Colitis ___Irritable Bowel Syndrome

f. Sensory

___Blurred vision ___Ringing in ears ___Hearing loss ___Chronic ear infection ___Loss of smell ___Loss of taste

g. Integumentary

___Skin cancer ___Psoriasis ___Eczema ___ Acne ___Hair loss ___Rash ___Changes in nail texture
___Changes in skin color ___Hair growth ___Hives ___History of skin disorder ___Itching ___Paresthesia ___Skin lesions
___Varicosities

h. Endocrine

___Thyroid issues ___Immune disorders ___ Hypoglycemia ___Frequent infections ___Swollen glands ___Low energy
___Cold intolerance ___Diabetes ___Excessive appetite ___Excessive hunger ___Excessive thirst ___Abnormal frequency of urination
___Goiter ___Hair loss ___Heat intolerance ___Unusual hair growth ___Voice changes ___Hands/feet cold ___Sweaty palms
___Chronic Fatigue Syndrome

i. Genitourinary

___Kidney stones ___Infertility ___Bedwetting ___Prostate issues ___ Erectile dysfunction ___PMS symptoms ____Menopause

j. Constitutional

___Fainting ___ Low libido ___Poor appetite ___Fatigue ___Sudden weight gain/loss (circle one) ___Weakness

k. **Psychologic**

___Insomnia ___Anxiety ___ Behavioral changes ___ Bi-polar disorder ___Confusion ___Convulsions ___Depression
___Memory loss ___Mood changes ___Loss or change in appetite

l. Allergy

___Anaphylaxis ___Food intolerance ___Itching ___Acute nasal congestion ___Chronic nasal congestion ___Sneezing

m. Hematologic

___Anemia ___Bleeding ___Blood clotting ___Blood transfusion ___Bruising easily ___Lymph node swelling

Illnesses- Do you have or suffer from any of the following?

___Pacemaker ___Learning disability ___Cancer ___Frequent flu/colds ___Alcoholism ___Drug addiction ___AIDS
___Chicken pox ___Glaucoma ___Gout ___Hepatitis ___HIV positive ___Malaria ___Mumps ___Polio ___Scarlet fever
___Sexually transmitted disease

Cognitive Function:

___Memory/ Recall problems ___Focus and Attention Challenges ___Brain Fog ___ Forgetfulness ___ Concussion
___ Lyme Disease ___ Stroke ___Tremors ___Sleep issues ____Attention deficit disorder _____ PTSD
___ Alzheimer's Disease ____Dementia ___Parkinson's Disease ___ Mercury Fillings ___ Regular Vaccinations

Does anyone else in your family have the same or similar problems? Please list _____

_____

Are there any other hereditary health issues or congenital diseases that you are concerned about?

_____

_____

How will you be paying for your visit? Cash___ Check___ Visa___ MasterCard___ Discover___

We are Out of Network providers for all Healthcare Insurance Companies, with the exception of Novitas Medicare- Part B. What an Out of Network provider means is that we do not have an agreement or contract with that insurance company. Because our doctors are Out of Network providers, we require all our patients to pay at the time of service. As a courtesy to all our patients, we will verify your insurance coverage and send your visits/claims to your specific insurance company. If there is any reimbursement for your care, your insurance company will send any such payment and/or correspondence directly to you/policy holder.

For patients who have Novitas Medicare - Part B coverage, adjustments may be considered for insurance coverage depending upon patient's deductible, diagnosis and frequency. If additional therapies are needed, Novitas Medicare-Part B will not consider them for coverage, only the chiropractic adjustment.

Patient or Guardian Initials: _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is evaluation of my physical health and the potential for improvement. I understand that all fees are due and payable at the time of service.

Patient or Guardian Signature: _____ Date: ____/____/____