Patient information & health history

Full name | **Today's date** | **Patient # (office)**

Address | **City** | **State** | **ZIP**

Email | **Cell phone** | **Home phone**

Birth date / age | **Marital status** | **Children** | **Preferred name**

Occupation | **Employer / retired**

Emergency contact / relationship | **Contact phone**

Referred by | **Family medical doctor / phone**

May we update your medical doctor regarding your care? ○ Yes ○ No

HISTORY OF PRESENT ILLNESS

Chief complaint / purpose of appointment

Symptoms began / accident date | **Days lost from work** | **Last physical exam**

Related to: ○ Auto ○ Work ○ Other

Similar condition before? When and how?

PAST MEDICAL HISTORY - SELECT ALL THAT APPLY

- ○ Broken bones
- ○ Seizures / convulsions
- ○ High / low blood pressure
- ○ Pacemaker
- ○ Ruptures / hernias
- ○ Alcoholism
- ○ Gallbladder disease
- ○ Circulatory problems
- ○ Congenital disease
- ○ Osteoarthritis
- ○ Stroke
- ○ Coughing blood
- ○ Drug addiction
- ○ Depression
- ○ Rheumatoid arthritis
- ○ Excessive bleeding
- ○ Epilepsy
- ○ Cancer
- ○ Eating disorder
- ○ HIV positive
- ○ Ulcers

Stroke / hypertension history; other health problems

Major illnesses, injuries, falls, accidents, surgeries / childbirth (with dates)

Conditions treated by a physician in the last year

Medications / drugs (dose and frequency); attach a list if needed

Allergies / sensitivities and reactions

Alcohol: drinks / week | **Tobacco / smoking: amount** | **Caffeine: amount / day**

Vitamins / supplements | **Exercise: type and frequency**

Family history, insurance & authorization

Full name **Date**

FAMILY HISTORY

Father: living / deceased; age, or age and cause of death

Mother: living / deceased; age, or age and cause of death

○ Adopted / family history unknown

For family conditions below, indicate the relative and maternal / paternal side.

Tuberculosis / cancer / mental illness **Diabetes / asthma / heart disease / stroke**

Kidney / lung / liver disease / arthritis / other

INSURANCE COVERAGE

○ Major medical ○ Workers' compensation ○ Medicaid ○ Medicare ○ Auto accident

Primary insurance company **ID / claim number** **Group #**

Subscriber / relationship **Subscriber birth date**

Subscriber address (if different from patient)

Secondary (if any) insurance company **ID / claim number** **Group #**

Subscriber / relationship **Subscriber birth date**

Subscriber address (if different from patient)

AUTHORIZATION AND RELEASE

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I further authorize the release of my medical records to this office. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%. We reserve the right to charge a $25.00 fee for appointments missed without 24-hours notice. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient signature **Date**

Guardian signature authorizing care (if applicable) **Date**

Symptoms & pain location

Full name **Date**

1. What is your major symptom?

2. If recurrent, when did it first occur and how did it begin?

Has it become:

- ○ Worse
- ○ Better
- ○ The same
- ○ Gradually worse

If worse, when and how?

3. Frequency:

- ○ Constant
- ○ Daily
- ○ Intermittent
- ○ Night only

4. Other symptoms that may be related to your main symptom

5. Describe your symptoms - select all that apply:

- ○ Sharp
- ○ Dull
- ○ Numbness
- ○ Tingling
- ○ Aching
- ○ Burning
- ○ Stabbing
- ○ Other

6. What relieves the problem? What have you tried that has not helped?

7. What makes it worse?

- ○ Standing
- ○ Sitting
- ○ Lying down
- ○ Bending
- ○ Lifting
- ○ Twisting
- ○ Other

8. Other major accidents (include dates)

9. Pregnant or possibly pregnant?

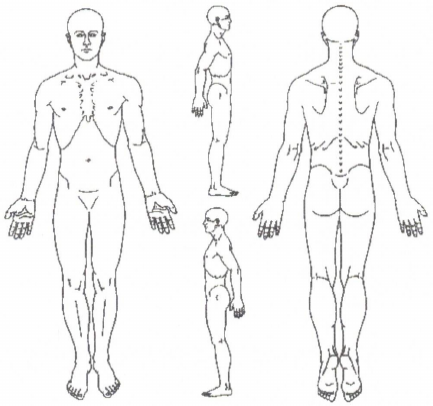
- ○ Yes
- ○ No
- ○ Uncertain
- ○ Not applicable

10. Remarks

Pain intensity: 0 = no symptoms; 10 = extreme symptoms. Circle one.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Mark an X on the diagram where you feel pain, numbness or tingling.



Clinician signature _____ Date _____

Wellness evaluation

Full name **Date**

Select symptoms you experience or conditions diagnosed by a practitioner. This evaluation guides discussion and does not establish a diagnosis or identify the cause of symptoms.

HEADACHES

- ○ Headaches
- ○ Migraines

HORMONAL CONCERNS

- ○ PMS
- ○ Emotional imbalance

GASTROINTESTINAL ISSUES

- ○ Abdominal bloating, cramps or painful gas
- ○ Irritable bowel syndrome
- ○ Ulcerative colitis
- ○ Crohn's / other intestinal disorders

RESPIRATORY CONDITIONS

- ○ Chronic sinusitis
- ○ Asthma
- ○ Allergies

JOINT CONCERNS

- ○ Knee, shoulder or spine

OTHER DIAGNOSED CONDITIONS

- ○ Diabetes mellitus
- ○ Lupus
- ○ Rheumatoid arthritis
- ○ Fibromyalgia
- ○ Chronic fatigue

THYROID CONDITIONS

- ○ Hashimoto's disease
- ○ Hypothyroidism
- ○ Hyperthyroidism

DEVELOPMENTAL / ATTENTION CONDITIONS

- ○ Autism
- ○ ADD / ADHD

SKIN CONDITIONS

- ○ Eczema
- ○ Skin rashes
- ○ Hives

SYMPTOM RATINGS - SELECT ONE RESPONSE PER ROW

Symptoms: 0 = none, 1 = mild, 2 = moderate, 3 = severe. Medication / antibiotic use: 0 = never, 1 = rarely, 2 = sometimes, 3 = often.

Constipation and/or diarrhea	○ 0 ○ 1 ○ 2 ○ 3		Asthma, hay fever or airborne allergies	○ 0 ○ 1 ○ 2 ○ 3	
Abdominal pain or bloating	○ 0 ○ 1 ○ 2 ○ 3		Confusion, poor memory or mood swings	○ 0 ○ 1 ○ 2 ○ 3	
Mucus or blood in stool	○ 0 ○ 1 ○ 2 ○ 3		Pain reliever use (aspirin, Tylenol, Motrin)	○ 0 ○ 1 ○ 2 ○ 3	
Joint pain / swelling or arthritis	○ 0 ○ 1 ○ 2 ○ 3		History of antibiotic use	○ 0 ○ 1 ○ 2 ○ 3	
Chronic or frequent fatigue / tiredness	○ 0 ○ 1 ○ 2 ○ 3		Alcohol consumption makes you feel sick	○ 0 ○ 1 ○ 2 ○ 3	
Food allergies / sensitivities / intolerance	○ 0 ○ 1 ○ 2 ○ 3		Gluten sensitivity or celiac disease	○ 0 ○ 1 ○ 2 ○ 3	
Sinus or nasal congestion	○ 0 ○ 1 ○ 2 ○ 3		Nausea	○ 0 ○ 1 ○ 2 ○ 3	
Chronic or frequent inflammation	○ 0 ○ 1 ○ 2 ○ 3		Weight concerns	○ 0 ○ 1 ○ 2 ○ 3	
Eczema, skin rashes or hives	○ 0 ○ 1 ○ 2 ○ 3				

Total (optional):

This total is not a diagnostic score and has no established cutoff in this form.

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