PERSONAL HISTORY

Name:__________ Address:__________

City:__________ State:__________ Zip:__________

Home Phone:__________ Birthdate:__________ Age:__________ Sex: □ M □ F

Cell Phone:__________ E-mail Address:__________

Social Security#:__________ Drivers License #:__________

Social Insurance #:__________ Circle One: Married Single Widowed Divorced Separated

Employer:__________ Type of work:__________

Business Phone:__________ Spouse’s Social Security #:__________

Name of Spouse:__________ Spouse’s Social Insurance #:__________

Spouse’s Employer:__________ Business Phone:__________

Type of Work:__________ Name and Ages of Children:__________

Referred to this office by:__________

Name and Number of Emergency Contact:__________ Relationship:__________

Who is responsible for your bill: Self & □ Spouse □ Workers’ Comp. □ Auto Insurance □ Medicare □ Medicaid or:

□ Personal Health Insurance (Name):__________ Contract #:__________

Insured Person’s Name:__________ Birthdate:__________

CURRENT HEALTH CONDITION

Unwanted Health Condition:__________

Other Doctors Seen For This Condition: □ No □ Yes, Other Doctor:__________

Type of Treatment:__________ Results:__________

When Did This Condition Begin:__________ Has This Condition Occurred Before: □ Yes □ No

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other:__________

Date of Accident:__________ Time of Accident:__________

Have you made a report of accident to your employer: □ Yes □ No

Drugs Currently Taken: □ Nerve Pills □ Pain killers/Muscle relaxers □ Blood Pressure medicine □ Insulin

□ Other:__________

Do You Wear A Shoe Lift: □ Yes □ No

Do you suffer from any health conditions other than that which you are now consulting us? __________

____

PAST HEALTH HISTORY

Please check and describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery

□ Broken Bones □ Other:__________

Major accidents/falls:__________

____

Hospitalization (other than above):__________

____

Previous chiropractic care: □ No □ Yes, Doctor’s name:__________ Last Visit Date:__________

Results from care:__________

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Below are a list of diseases which may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

□ Pneumonia
□ Small Pox
□ Arthritis
□ Whooping Cough
□ Heart Disease
□ Mumps
□ Pleurisy
□ Tuberculosis
□ Cancer
□ Lumbago
□ Influenza
□ Polio
□ Diabetes
□ Mental Disorders
□ Measles
□ Rheumatic Fever
□ Chicken Pox
□ Epilepsy
□ Anemia
□ Thyroid
□ Eczema
□ HIV

Intake: □ Coffee □ Tea □ Alcohol □ Cigarettes □ White Sugar

Check any of the following you have had the past 6 months:

Musculo-Skeletal Code
□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/Stiffness
□ Walking Problems
□ Difficult Chewing/Clicking Jaw
□ General Stiffness

Nervous System Code
□ Nervous
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion
□ Depression
□ Fainting
□ Convulsions
□ Cold/Tingling Extremities
□ Stress

General Code
□ Fatigue
□ Allergies
□ Loss of sleep
□ Fever
□ Headaches

Genito-Urinary Code
□ Bladder trouble
□ Painful excessive urination
□ Discolored urine

□ Poor/Excessive Appetite
□ Excessive Thirst
□ Frequent nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver problems
□ Gall bladder problems
□ Weight trouble
□ Abdominal cramps
□ Gas/bloating after meals
□ Heartburn
□ Black/bloody stool
□ Colitis

C-V-R Code
□ Chest pain
□ Short breath
□ Blood pressure problems
□ Irregular heartbeat
□ Heart problems
□ Lung problems/congestion
□ Varicose veins
□ Ankle swelling
□ Stroke

□ Menstrual cramps
□ Vaginal pain/infection
□ Breast pain/lumps
□ Prostate/Sexual dysfunction
□ Other problems
□ Infertility
□ ________________________
□ ________________________

Females Only:
Last period:________________
Are you pregnant: □ Yes □ No □ Maybe

EENT Code
□ Vision problems
□ Dental Problems
□ Sore throat
□ Ear aches
□ Hearing difficulty
□ Stuffed nose

Family History:
The following members have the same of similar conditions as I do:
□ Mother
□ Father
□ Brother
□ Sister
□ Spouse
□ Child

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program. I would prefer:

□ **Relief Care:** Care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak but not fixing the leak itself.

□ **Corrective Care:** Differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office 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 Doctor's office 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, 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. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives 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.

Patient Signature:________________________________ Printed:________________________________ Date:__________