

Insurance Carrier: _____ Policy No.: _____
 Agent: _____ Claims Office Address: _____

FOR OFFICE USE ONLY

Confidential Health History

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

PERSONAL:

Name: _____ Sex: _____ Marital Status: _____ Date of Birth: _____ Cell _____
(Name title, first name, and last name) M or F M,S,D,W month day year Home Phone: _____
Area Code Number

Address: _____ City: _____ State: _____ Zip Code: _____
(Include street type, such as ST., AVE., etc.)

Who referred you to our office? _____ Your Occupation: _____
(If student, unemployed, retired, child, housewife, etc., please so indicate)

Social Sec. #: _____ Business Phone: _____ Company Name: _____ Location: _____
Area Code Number

Spouse's First name: _____ Spouse's Soc. Sec. #: _____ Spouse's Employer: _____ Location: _____
 Email: _____

HEALTH REPORT:

Is this visit for an annual physical? Yes ___ No ___ Height: Feet ___ Inches ___ Weight: _____

Please describe the principal health problems for which you came to this office. _____

List any other doctors seen for this: _____

List any diagnosis(es) and type of treatment(s): _____

Have you lost any days of work? Yes ___ No ___ Dates: _____

Have you had similar accidents or injuries before? Yes ___ No ___ If yes, explain: _____

List the names of any relatives that have or have had a similar problem: _____

Have you or any relative received chiropractic treatment previously? Yes ___ No ___ If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? Yes ___ No ___ If yes, explain: _____

Are you currently under medication? Yes ___ No ___ If so, what kind? _____

Have you been under medication in the past? Yes ___ No ___ If so, what kind? _____

List the approximate dates of any surgery or unusual diseases you have had: _____

If your condition is due to an accident, not work related, please answer the following:

Date _____ Time _____ AM ___ PM ___ of accident. Police report made? _____

Place - Location of accident: _____

Do you have an attorney that has advised you in this case? Yes ___ No ___ If yes, list the name and address: _____

Please describe the accident: _____

If your condition is due to a work-related accident, please answer the following:

Have you notified your employer? Yes ___ No ___ If yes, who or what department? _____

Date injured _____ Time _____ AM ___ PM ___ Date last worked _____

Injured at: _____
(Address, city, county, and state)

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of one of the following codes:

Codes: 1 for presently have; 2 for previously had

MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urine
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
 Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR-RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

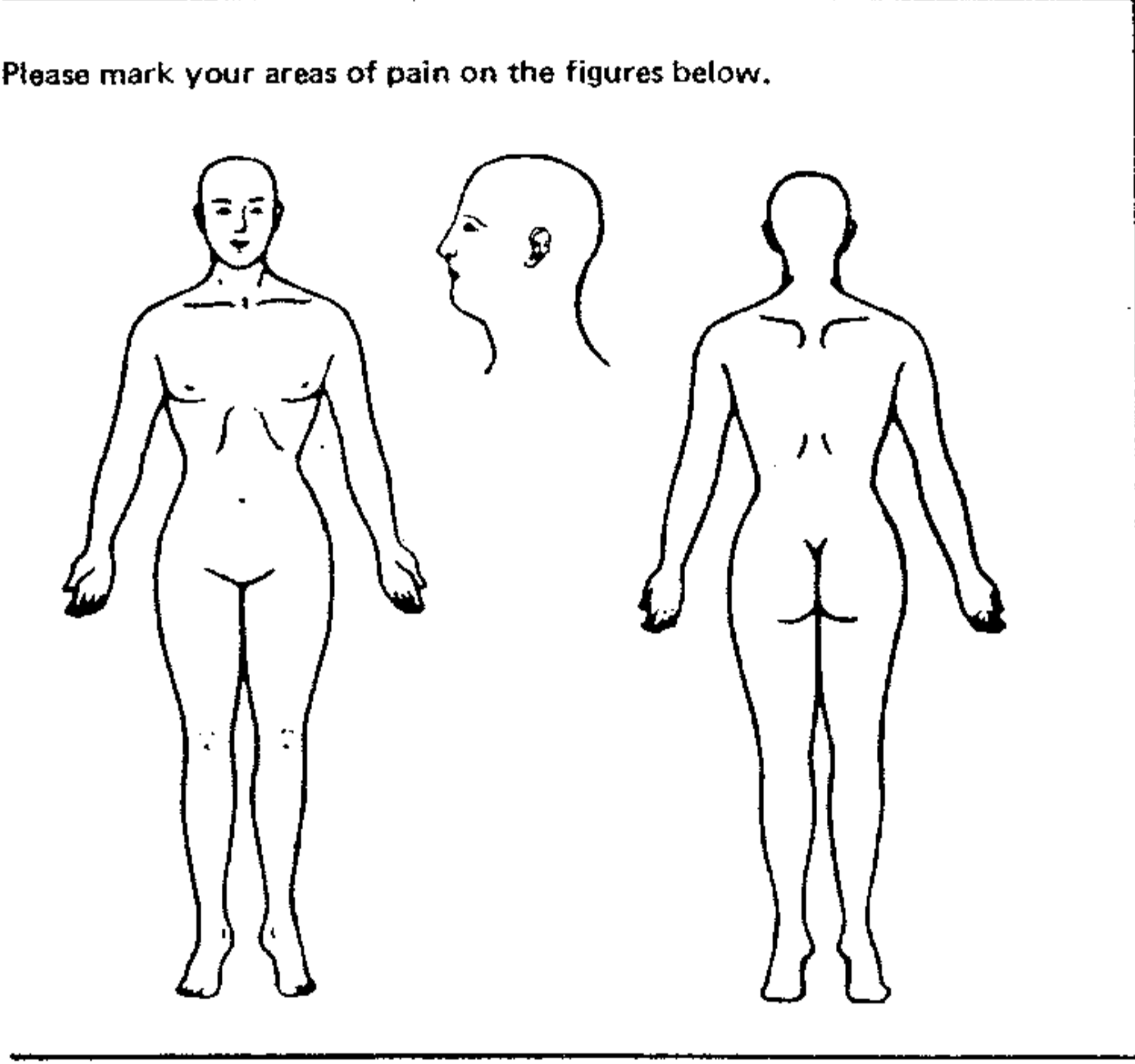
EYE, EAR, NOSE, AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

In case of emergency, please notify _____
 address _____ phone _____



Please mark your areas of pain on the figures below.

I understand that all treatments, X-rays and laboratory examinations are to be paid for as they are received or definite financial arrangements made in advance.

 Patient's Signature Date
 DO NOT WRITE BELOW THIS LINE

POP, PD, PS (F/A), FT, NOD, LOT, DOC, HP, AEP, NLW.

Patient accepted? Yes _____ No _____ Date _____ Doctor's signature _____