Personal history

Name______________________________________Address_________________________________

City____ State___________________ zip code_________

Home phone________________________________ birth date_______ age______ sex: __ M __ F

Social security#_____________________ circle: _ married _single _widowed _ divorced _separated

Business employer____________________________ type of work_______________________

Business Phone______________________________ Spouse Social Security#_______________________

Name of spouse_______________________________

Spouse's employer____________________________Business phone__________________________

Type of work_________________________________ name & ages or children_____________________

Referred to this office by_____________________Email address______________________________

Name and number of emergency contact________________________Relationship_______________

Who is responsible for this bill you and __workers comp __ auto insurance __Medicare

Personal health history (name)____________________ID number______________________________

Current health conditions

Purpose of this appointment____

Other doctors seen for this conditions: __ yes __ no Who________________________________

Type of treatment __________________________________results______________________________

When this condition begin_______________________ has this condition occurred before: __ yes __no

Is condition: related to: __ auto accident __ home injury __ fall other_____________________

Date of accident___________________________________ time of accident____________________

Have you made a report of your accident to your employer: __ yes __ no

Drugs you now take: __ nerve pills __ pain killers/muscle relaxes __ blood pressure __ insulin

Other meds____

Do you wear a shoe lift: __ yes __no

Do you suffer from any medical conditions other than which you are now consulting us?____________

____

Past health history

Please check and describe:

Major surgery/operations: __ appendectomy __ tonsillectomy __gallbladder __hernia

__ back surgery __Broken bones other______________________________

Major accidents of falls____

Hospitalization (other than above)____

Previous chiropractic care: ___none

Doctor's name & approximate date of last visit____

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

Please put **Y** for Yes for any of the following diseases you have had:

____Pneumonia	____ mumps	_____influenza	**Intake**
____Rheumatic fever	_____smallpox	_____ pleurisy	___coffee
____Polio	_____chickenpox	_____arthritis	___tea
____Tuberculosis	_____diabetes	_____ epilepsy alcohol	___ cigarettes
____Whooping cough	____cancer	_____mental disorder	___white sugar
____Anemia	____heart disease	_____Lumbago	
____Measles	____thyroid	_____eczema	

Have you been tested HIV-positive? ___Yes ___ No

Please mark **Y for yes** for any of the following you have had the past six months:

Musculoskeletal code

_____Low back pain

_____Pain between shoulders

_____Neck pain

_____Arm pain

_____Joint pain

_____Walking problems

_____Difficulty chewing/clicking jaw

_____gas/loading after meals

_____heartburn

_____black/bloody stools

_____ colitis

genital urinary code

_____bladder trouble

_____painful excessive urination

_____Discolored urine

females only

when was your last period

____

are you pregnant? ______

Nervous system code

_____Nervous

_____Numbness

_____Paralysis

_____Dizziness

_____Forgetfulness

_____Confusion/depression

_____Fainting

_____Convulsions

_____Stress stroke

C.-V-R code

______chest pain

_____shortness of breath

_____blood pressure problems

_____irregular heartbeat

_____heart problems

______lung problems / congestion

______ varicose veins

______ ankle swelling

General code

_____Fatigue

EENT code

______vision problems

____allergies

____loss of sleep

____fever

____headaches

_____dental problems

____sore throat

____earaches

____hearing difficulty

____stuff nose

Gastrointestinal code

____Poor excessive appetite

____ Excessive thirst

____frequent nausea

____Vomiting

____diarrhea

____constipation of the problems system

____Hemorrhoids

____Liver child

____Gallbladder problems

____Weight trouble

____Abdominal cramps

male/female code

____menstrual irregularity

____Menstrual cramps

____vaginal pain/infection

____breast pain/lumps

____prostate /sexual dysfunction

family history

the following members have a same or similar problem

____mother

____father

____brother

____sister