# Confidential
# Health Information

Please allow our staff to photocopy your insurance card and details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Dr. Donovan Stewart's
Chiropractic Health & Fitness Center
3371 Whittle Springs Rd
865-687-5700
stewartchiro.com

____________________
Today's Date

Name _____________________________________________ Age _____ Date of Birth ____-____-____
Address ______________________________________ E-Mail Address ___________________________
City ____________________State _________ Zip ______ Social Security # _____-____-______
Phone #'s: Home _____________ Cell ______________ Work _______________ Fax___________
Preferred method of contact? ❑ Home phone ❑ Cell phone ❑ Work phone
May we contact you at work? ❑ Yes ❑ No
Employment Status: ❑ Employed ❑ Self Employed ❑ Student ❑ Retired ❑ Disabled
Occupation ____________________________ Employer ___________________________________
❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Male ❑ Female # of Children ________
Name of Spouse _________________ Names & ages of Children ______________________________
______________________________________________________________________________________
Main reason for consulting our office today? _______________________________________
Are you here because of ❑ Car accident ❑ Work injury ❑ Other injury ___________________
I am seeking: ❑ I want the Doctor to recommend what he feels is best for me
❑ Correction of the underlying condition, if possible ❑ Temporary relief only
Referred by: ____________________________❑ Doctor ❑ Friend ❑ Family ❑ Co-worker
Previous chiropractic care? ❑ Yes ❑ No If yes, when was your last adjustment? ______________
What is your current height? __________________ Current weight? ________________
Medication Allergies: ______________________________________________________________

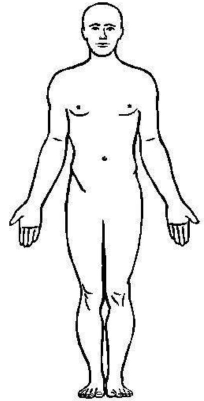
**Demographics requested by the government**
**Gender**: ❑ Male ❑ Female
**Race**: ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Multi-Racial or Other ___________
❑ Decline to answer
**Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to specify
**Preferred Language**: ❑ English ❑ Spanish ❑ Unspecified
**Smoking Status:** ❑ Never A Smoker ❑ Former Smoker ❑ Current Every Day Smoker
❑ Current Some Day Smoker ❑ Heavy Smoker ❑ Light Smoker
If you are a current smoker, what is your interest in quitting? No Interest --------------------Very Interested
**Diabetes:** ❑ Yes ❑ No Do you take diabetes medications? ❑ Yes ❑ No
**High Blood Pressure:** ❑ Yes ❑ No Do you take blood pressure medications? ❑ Yes ❑ No
Recent Blood Pressure (if you know): _________________ Date taken: __________________________
**Recent Tests or Studies**
Have you had an x-ray, CT scan, or MRI of your spine in the last 28 days? ❑ Yes ❑ No
Other significant tests or lab work? ❑ Yes ❑ No What, when,where?:___________________
__________________________________________________________________________________
__________________________________________________________________________________

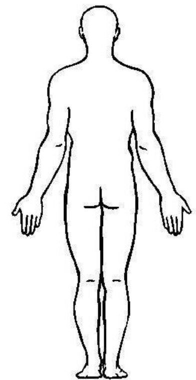
***Primary Complaint***

The primary symptom that prompted me to seek care today is: ______________________

________________________________________________________________________________

Please indicate where you hurt on the diagrams below.





**And is the result of :** ◯ An accident or injury (◯ work ◯ Auto ◯ Other ______________)
◯ A worsening long term problem
◯ An interest in Wellness care
◯ Other ______________________________________________________

**Onset:** When did you first notice the current symptom? ________________________________________

**Since it began:** Is it ◯ The same ◯ Better ◯ Worse ◯ Variable

**Is the pain:** ◯ Sharp ◯ Dull ◯ Constant ◯ Intermittent ◯ Radiating
◯ Mild ◯ Moderate ◯ Moderately Severe ◯ Severe ◯ Intolerable

**Prior interventions:** What have you done to relieve the symptoms?
◯ Prescription medications ◯ Over the counter drugs ◯ Homeopathics
◯ Physical therapy ◯ Surgery ◯ Acupuncture ◯ Chiropractic
◯ Massage ◯ Ice ◯ Heat ◯ Other: ______________________________

***Secondary Complaint***

The secondary symptom that prompted me to seek care today is: ________________________________

________________________________________________________________________________

**And is the result of :** ◯ An accident or injury (◯ work ◯ Auto ◯ Other ______________)
◯ A worsening long term problem
◯ An interest in Wellness care
◯ Other ______________________________________________________

**Onset:** When did you first notice the current symptom? ____________________________________

**Since it began:** Is it ◯ The same ◯ Better ◯ Worse ◯ Variable

**Is the pain:** ◯ Sharp ◯ Dull ◯ Constant ◯ Intermittent ◯ Radiating
◯ Mild ◯ Moderate ◯ Moderately Severe ◯ Severe ◯ Intolerable

**Prior interventions:** What have you done to relieve the symptoms?
◯ Prescription medications ◯ Over the counter drugs ◯ Homeopathics
◯ Physical therapy ◯ Surgery ◯ Acupuncture ◯ Chiropractic
◯ Massage ◯ Ice ◯ Heat ◯ Other: ______________________________

***Additional Complaint***

Another symptom that prompted me to seek care today is: _____________________________________

________________________________________________________________________________

**And are the result of :** ◯ An accident or injury (◯ work ◯ Auto ◯ Other ______________)
◯ A worsening long term problem
◯ An interest in Wellness care
◯ Other ______________________________________________________

**Onset:** When did you first notice the current symptom? ____________________________________

**Since it began:** Is it ◯ The same ◯ Better ◯ Worse ◯ Variable

**Is the pain:** ◯ Sharp ◯ Dull ◯ Constant ◯ Intermittent ◯ Radiating
◯ Mild ◯ Moderate ◯ Moderately Severe ◯ Severe ◯ Intolerable

**Prior interventions:** What have you done to relieve the symptoms?
◯ Prescription medications ◯ Over the counter drugs ◯ Homeopathics
◯ Physical therapy ◯ Surgery ◯ Acupuncture ◯ Chiropractic
◯ Massage ◯ Ice ◯ Heat ◯ Other: ______________________________

What else should Dr. Stewart know about your current condition? _______________________________________________________

________________________________________________________________________________________________

How does your current condition interfere with your life? (work, recreation, household activities, personal relationships) ____________

________________________________________________________________________________________________

**Review of Symptoms** : Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

**Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | None ◯ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Osteoporosis | ◯ | ◯ | Arthritis | ◯ | ◯ | Scoliosis | ◯ | ◯ | Neck pain | ◯ | ◯ | Back pain | ◯ | ◯ | Hip disorders | |
| ◯ | ◯ | Knee injuries | ◯ | ◯ | Foot/ankle | ◯ | ◯ | Shoulder | ◯ | ◯ | Elbow/wrist | ◯ | ◯ | TMJ issues | ◯ | ◯ | Poor posture | |

**Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | None ◯ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anxiety | ◯ | ◯ | Depression | ◯ | ◯ | Headache | ◯ | ◯ | Dizziness | ◯ | ◯ | Pins/needles | ◯ | ◯ | Numbness | |

______________________

(continued from previous page)

**Cardiovascular**

Had Have ◯ ◯ High BP | Had Have ◯ ◯ Low BP | Had Have ◯ ◯ High cholesterol | Had Have ◯ ◯ Poor circulation | Had Have ◯ ◯ Angina | Had Have ◯ ◯ Excessive bruising | None ◯

**Respiratory**

Had Have ◯ ◯ Asthma | Had Have ◯ ◯ Apnea | Had Have ◯ ◯ Emphysema | Had Have ◯ ◯ Hay Fever | Had Have ◯ ◯ Shortness Of breath | Had Have ◯ ◯ Pneumonia | None ◯

**Digestive**

Had Have ◯ ◯ Anorexia/bulemia | Had Have ◯ ◯ Ulcer | Had Have ◯ ◯ Food Sensitivities | Had Have ◯ ◯ Heartburn | Had Have ◯ ◯ Constipation | Had Have ◯ ◯ Diarrhea | None ◯

**Sensory**

Had Have ◯ ◯ Blurred vision | Had Have ◯ ◯ Ringing ears | Had Have ◯ ◯ Hearing loss | Had Have ◯ ◯ Chronic ear infections | Had Have ◯ ◯ Loss of smell/taste | None ◯

**Skin**

Had Have ◯ ◯ Skin cancer | Had Have ◯ ◯ Psoriasis | Had Have ◯ ◯ Eczema | Had Have ◯ ◯ Acne | Had Have ◯ ◯ Hair loss | Had Have ◯ ◯ Dermatitis | None ◯

**Endocrine**

Had Have ◯ ◯ Thyroid Disease | Had Have ◯ ◯ Immune disorders | Had Have ◯ ◯ Hypoglycemia | Had Have ◯ ◯ Frequent infections | Had Have ◯ ◯ Swollen glands | Had Have ◯ ◯ Low energy | None ◯

**Genitourinary**

Had Have ◯ ◯ Kidney stones | Had Have ◯ ◯ Infertility | Had Have ◯ ◯ Bedwetting | Had Have ◯ ◯ Prostate issues | Had Have ◯ ◯ Erectile dysfunction | Had Have ◯ ◯ PMS symptoms | None ◯

**Constitutional**

Had Have ◯ ◯ Fainting | Had Have ◯ ◯ Low libido | Had Have ◯ ◯ Poor appetite | Had Have ◯ ◯ Fatigue | Had Have ◯ ◯ Sudden Weight gain/loss | Had Have ◯ ◯ Weakness | None ◯

**Past Personal, Family and Social History**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

**Illnesses**

Check the illnesses you have **Had** in the past or **Have** now:

| Had | Have | |
|---|---|---|
| ◯ | ◯ | AIDS |
| ◯ | ◯ | Alcoholism |
| ◯ | ◯ | Allergies |
| ◯ | ◯ | Arteriosclerosis |
| ◯ | ◯ | Cancer |
| ◯ | ◯ | Chicken pox |
| ◯ | ◯ | Diabetes |
| ◯ | ◯ | Epilepsy |
| ◯ | ◯ | Glaucoma |
| ◯ | ◯ | Gout |
| ◯ | ◯ | Heart Disease |
| ◯ | ◯ | Hepatitis |
| ◯ | ◯ | HIV pos |
| ◯ | ◯ | Malaria |
| ◯ | ◯ | Measles |
| ◯ | ◯ | Multiple Sclerosis |
| ◯ | ◯ | Mumps |
| ◯ | ◯ | Polio |
| ◯ | ◯ | Rheumatic fever |
| ◯ | ◯ | Scarlet fever |
| ◯ | ◯ | STD |
| ◯ | ◯ | Stroke |
| ◯ | ◯ | Tuberculosis |
| ◯ | ◯ | Typhoid fever |
| ◯ | ◯ | Ulcer |
| ◯ | ◯ | Other ________________ |

**Operations**

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery

________________________________

- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine: ______________________

________________________________

- ◯ Tonsilectomy
- ◯ Vasectomy
- ◯ Other: ______________________

________________________________

**Injuries**

Have you ever…

- ◯ Had a fracture or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used a crutch or other support

**Treatments**

| Past | Currently | |
|---|---|---|
| ◯ | ◯ | Acupuncture |
| ◯ | ◯ | Antibiotics |
| ◯ | ◯ | Birth control pills |
| ◯ | ◯ | Blood transfusions |
| ◯ | ◯ | Chemotherapy |
| ◯ | ◯ | Chiropractic care |
| ◯ | ◯ | Dialysis |
| ◯ | ◯ | Herbs |
| ◯ | ◯ | Homeopathy |
| ◯ | ◯ | Hormone replacement |
| ◯ | ◯ | Inhaler |
| ◯ | ◯ | Massage therapy |
| ◯ | ◯ | Physical therapy |

**Medications**

Please list current medications:

____________________________

____________________________

____________________________

____________________________

____________________________

____________________________

____________________________

____________________________

____________________________

**Family History**

Some health issues are hereditary. Tell Dr. Stewart about the health of your immediate family members.

| Relative | Age (if living) | State of health: Good | Poor | Illnesses | Age at death |
|---|---|---|---|---|---|
| Mother | _____________ | ◯ | ◯ | ____________________ | |
| Father | _____________ | ◯ | ◯ | ____________________ | |
| Sister 1 | _____________ | ◯ | ◯ | ____________________ | |
| Sister 2 | _____________ | ◯ | ◯ | ____________________ | |
| Brother 1 | _____________ | ◯ | ◯ | ____________________ | |
| Brother 2 | _____________ | ◯ | ◯ | ____________________ | |
| _________ | _____________ | ◯ | ◯ | ____________________ | |

_______________________

Are there any other hereditary health issues that you know about? ______________________________________________________________________

## Social History (Check any that apply)

| | | | |
|---|---|---|---|
| Alcohol use | ◯ Daily | ◯ Weekly | How much? __________________ |
| Coffee use | ◯ Daily | ◯ Weekly | How much? __________________ |
| Tobacco use | ◯ Daily | ◯ Weekly | How much? __________________ |
| Exercising | ◯ Daily | ◯ Weekly | How much? __________________ |
| Pain relievers | ◯ Daily | ◯ Weekly | How much? __________________ |
| Soft drinks | ◯ Daily | ◯ Weekly | How much? __________________ |
| Water intake | ◯ Daily | ◯ Weekly | How much? __________________ |

| | | |
|---|---|---|
| Prayer or meditation? | ◯ Yes | ◯ No |
| Job pressure/stress? | ◯ Yes | ◯ No |
| Financial peace? | ◯ Yes | ◯ No |
| Vaccinated? | ◯ Yes | ◯ No |
| Mercury fillings? | ◯ Yes | ◯ No |
| Recreational drugs? | ◯ Yes | ◯ No |

## 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 |
|---|---|---|---|---|
| Sitting | ◯ | ◯ | ◯ | ◯ |
| Rising out of chair | ◯ | ◯ | ◯ | ◯ |
| Standing | ◯ | ◯ | ◯ | ◯ |
| Walking | ◯ | ◯ | ◯ | ◯ |
| Lying down | ◯ | ◯ | ◯ | ◯ |
| Bending over | ◯ | ◯ | ◯ | ◯ |
| Climbing stairs | ◯ | ◯ | ◯ | ◯ |
| Using a computer | ◯ | ◯ | ◯ | ◯ |
| Getting in/out of car | ◯ | ◯ | ◯ | ◯ |
| Driving a car | ◯ | ◯ | ◯ | ◯ |
| Looking over shoulder | ◯ | ◯ | ◯ | ◯ |
| Caring for family | ◯ | ◯ | ◯ | ◯ |

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Grocery shopping | ◯ | ◯ | ◯ | ◯ |
| Household chores | ◯ | ◯ | ◯ | ◯ |
| Lifting objects | ◯ | ◯ | ◯ | ◯ |
| Reaching overhead | ◯ | ◯ | ◯ | ◯ |
| Showering or bathing | ◯ | ◯ | ◯ | ◯ |
| Dressing myself | ◯ | ◯ | ◯ | ◯ |
| Love life | ◯ | ◯ | ◯ | ◯ |
| Getting to sleep | ◯ | ◯ | ◯ | ◯ |
| Staying asleep | ◯ | ◯ | ◯ | ◯ |
| Concentrating | ◯ | ◯ | ◯ | ◯ |
| Exercising | ◯ | ◯ | ◯ | ◯ |
| Yard work | ◯ | ◯ | ◯ | ◯ |

**What is the major stressor in your life?** ______________________________________________________________________

**How much sleep do you average per night?** _________ Hrs. **What is your preferred sleeping position?** __________________________________

**Describe your typical eating habits:** ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

**What would be the most significant thing that you could do to improve your health?** ____________________________________________________

**What additional health goals do you have?** _______________________________________________________________________________

### Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ Initials — I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ Initials — I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ Initials — I realize that any x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): ________________________

_____ Initials — I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

_____ Initials — I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ Initials — I authorize payment of insurance benefits (including Medicare/Medigap) to be made directly to Chiropractic Health & Fitness Center for services rendered.

_____ Initials — To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

________________________________________________________ ________________________________

Patient (or guardian's) signature Date (MM/DD/YYYY