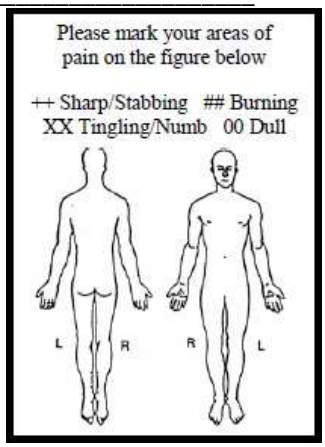
CONFIDENTIAL PATIENT HEALTH HISTORY

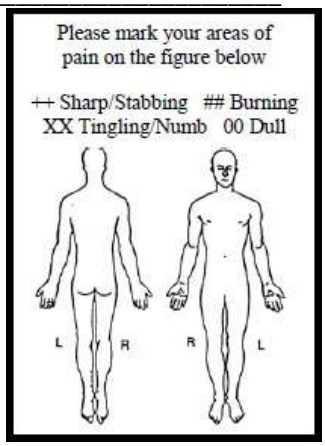
Name: _____ DOB: _____ Today's Date: _____
Home Phone #: _____ Cell Phone #: _____
Address: _____ City: _____State: _____ Zip: _____
Sex: M F Marital Status: M S W D Spouse's Name: _____ # of children? _____
Occupation_____ Employer_____
Who may we thank for referring you? _____
Have you had chiropractic care? □ Yes □ No If so, who was the doctor and when? _____
Would you like to receive □ Text Reminders, Cellular Carrier: _____

PRIMARY CONDITION – Please describe what brought you into the office:
Please describe your primary complaint: _____
When did it start? _____ have you had it in the past: □ Y □ N When: _____
Please check the appropriate box: The pain is □ constant □ it comes and goes
On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describes the pain: □ Sharp/Stabbing Pain □ Burning
□ Dull Pain □ Tingling □ Numbness □ Weakness □ Restriction □ Other _____
Does your pain travel from the point of pain? □ Y □ N If yes, where: _____
What makes it better? □ Chiropractic □ Ice Heat □ Massage □ Medication
□ Resting □ Sitting □ Standing □ Walking □ Lying Down □ Other _____
What makes it worse? □ Bowel Movements □ Breathing □ Coughing □ Driving
□ Sitting □ Lying Down □ Sneezing □ Walking □ Working □ Other _____
Have you missed any school/work due to this complaint? □ Y □ N
Is this the result of an automobile accident: □ Y □ N Work related injury: □ Y □ N
If yes, to either question above, please explain: _____



Have you received any other treatment for this condition: □ Y □ N If yes, indicate treatment □ Chiropractic □ Physical Therapy
□ Surgery □ Other _____ Doctor's Name who provided Treatment: _____
*DOCTOR USE ONLY: _____
_____

SECONDARY CONDITION – Please describe additional area of complaint
Please describe your secondary complaint: _____
When did it start? _____ Have you had it in the past: □ Y □ N When: _____
Please check the appropriate box: The pain is □ constant □ it comes and goes
On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describes the pain: □ Sharp/Stabbing Pain □ Burning
□ Dull Pain □ Tingling □ Numbness □ Weakness □ Restriction □ Other _____
Does your pain travel from the point of pain? □ Y □ N If yes, where: _____
What makes it better? □ Chiropractic □ Ice Heat □ Massage □ Medication
□ Resting □ Sitting □ Standing □ Walking □ Lying Down □ Other _____
What makes it worse? □ Bowel Movements □ Breathing □ Coughing □ Driving
□ Sitting □ Lying Down □ Sneezing □ Walking □ Working □ Other _____
Have you missed any school/work due to this complaint? □ Y □ N
Is this the result of an automobile accident: □ Y □ N Work related injury: □ Y □ N
If yes, to either question above, please explain: _____



Have you received any other treatment for this condition: □ Y □ N If yes, indicate treatment □ Chiropractic □ Physical Therapy
□ Surgery □ Other _____ Doctor's Name who provided Treatment: _____
*DOCTOR USE ONLY: _____
_____

Is there anything else going on that you think the doctor should know about?
_____
_____

Have you ever had any of the following in the past?

Childhood Illness	□ Y □ N	Large Amounts of Stress	□ Y □ N	Played Youth Sports	□ Y □ N
Auto Accident	□ Y □ N	Emotional Trauma	□ Y □ N	Play Adult Sports	□ Y □ N
Serious Fall	□ Y □ N	Physical Trauma	□ Y □ N	Surgery	□ Y □ N

If yes, list here: _____
_____

Do/did you smoke? □ Y □ N, how often/much? _____
Do/did you drink alcohol? □ Y □ N, how often/much? _____
Do/did you drink soda? □ Y □ N, how often/much? _____

On a scale of 0 – 10, rate your current stress level:
(0 = none / 10 = extreme)

Occupational: _____ Personal: _____

Rate these following as Poor, Good, or Excellent:

Diet: _____ What do you eat? _____
Exercise: _____ When and what? _____
Sleep: _____ Hours per day? _____
General Health: _____

Please list any current medications: _____

Activities of Daily Living: Please circle the activities that are affected by your current complaint.

Bathing	Cooking	Laying down	Sleeping
Bending	Daily pet care	Lifting items	Sneezing
Brushing teeth	Dressing	Reading	Sports
Caring for family	Swallowing	Reaching	Static sitting
Carrying items	Driving	Running	Static standing
Changing of pos.	Eating	Shaving	Work activities
Climbing stairs	Exercising	Showering	Yard work
Computer use	Getting out of bed	Sexual activities	Other: _____
Concentration	Household chores		

Females Only: Are you currently having menstrual cycles? □ Y □ N If yes, when was the first day of your last cycle? _____
Is there any chance you are pregnant? □ Y □ N If yes, how many weeks? _____

Family History: Insert age and check any box that applies

	Age (if living)	Heart Disease	High Cholesterol	High Blood Pressure	Diabetes	Cancer	Anemia
Self							
Mom							
Dad							
Brother							
Sister							
Other:_____							

Subjective Health Assessment

Please rate the following symptoms that you have experienced during the past 30 days

0 = Never 1 = Occasional and Mild 2 = Occasional and Severe 3 = Often and Mild 4 = Often and Severe

Head

0 1 2 3 4 Headache
0 1 2 3 4 Faintness
0 1 2 3 4 Dizziness
0 1 2 3 4 Sleeplessness

Eyes, Ears, Nose, Throat

0 1 2 3 4 Stuffy Nose
0 1 2 3 4 Sinus Trouble
0 1 2 3 4 Hay Fever
0 1 2 3 4 Sneezing
0 1 2 3 4 Nasal Congestion
0 1 2 3 4 Swollen Eyes
0 1 2 3 4 Reddened Eyes
0 1 2 3 4 Watery, Itchy Eyes
0 1 2 3 4 Dark Circles Under Eyes
0 1 2 3 4 Earache, Ear Infection
0 1 2 3 4 Ringing in the Ears
0 1 2 3 4 Coughing
0 1 2 3 4 Sore Throat
0 1 2 3 4 Hoarseness, Loss of Voice
0 1 2 3 4 Canker Sore

Memory, Emotions

0 1 2 3 4 Mood Swings
0 1 2 3 4 Anxiety, Nervousness
0 1 2 3 4 Anger, Irritability
0 1 2 3 4 Aggressiveness
0 1 2 3 4 Depression
0 1 2 3 4 Poor Memory
0 1 2 3 4 Confusion
0 1 2 3 4 Lack of Concentration
0 1 2 3 4 Difficulty Making Decisions

Weight

0 1 2 3 4 Binge Eating, Drinking
0 1 2 3 4 Craving Certain Foods
0 1 2 3 4 Excessive Weight
0 1 2 3 4 Water Retention
0 1 2 3 4 Overweight

Heart, Lungs

0 1 2 3 4 Irregular Heart Beat
0 1 2 3 4 Rapid, Pounding Heart Beat
0 1 2 3 4 Chest Pain
0 1 2 3 4 Chest Congestion
0 1 2 3 4 Asthma
0 1 2 3 4 Bronchitis

Skin

0 1 2 3 4 Acne
0 1 2 3 4 Dry, Scaly Skin
0 1 2 3 4 Hair Loss
0 1 2 3 4 Hot Flashes

Digestion

0 1 2 3 4 Nausea, Vomiting
0 1 2 3 4 Diarrhea
0 1 2 3 4 Constipation
0 1 2 3 4 Heartburn
0 1 2 3 4 Stomach Pain
0 1 2 3 4 Bloating
0 1 2 3 4 Belching, Gas

Joints

0 1 2 3 4 Stiffness, Lack of Motion
0 1 2 3 4 Arthritis
0 1 2 3 4 Pain in Joints
0 1 2 3 4 Pain in Muscles

Energy Levels

0 1 2 3 4 Weakness
0 1 2 3 4 Fatigue
0 1 2 3 4 Hyperactivity
0 1 2 3 4 Restlessness

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, AND HEALTHCARE OPERATIONS.

I**, _____** hereby state that by signing this consent, I acknowledge and agree as follows:

____ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. There will be a missed appointment fee of $25 for any appointments where I do not give at least a 24 hour notice of cancellation or I do not show up for my appointment time.

____ 4. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Messages being set to the email addresses I have provided
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 5. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

____ 6. I give permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me. I verify that the information I have provided in this document is true and I give the doctor consent to treat me. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Patient's Name (Printed): _____

Patient's Name (Signed):_____ Date: _____