BOWERS Chiropractic Center, P.C.

Date	I.D. #

Patient Health History

Name: _____ Age: _____ Date of Birth: _____ Sex: ☐M☐F

Address: _____ City: _____ State:___ Zip: _____

Phone (Home): _____ (Work):_____ (Cell):_____

E-Mail Address: _____ Marital Status:❑S ❑M ❑D ❑W Number of Children: ___

Occupation: _____ Social Security Number: _____

Employer: _____ Driver's License Number: _____

Spouse's Name: _____ Spouse's Age: ____ Spouse's Date of Birth: _____

Spouse's Occupation: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Phone (Work): _____

Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____

Insurance Company: _____ Spouse's Insurance Company: _____

How did you hear about this office: _____ Referred by: _____

Family Dr's Name: _____ Address: _____

Send report? ☐Yes ☐No

Past Chiropractic Care: ☐Yes ☐No When? _____ Doctor's Name: _____ Results: _____

Purpose of this appointment: _____

Are your present problems due to an injury? ☐Yes ☐No ☐On Job ☐Auto Accident ☐Personal Injury ☐Other: _____

Has the accident been reported? ☐Yes ☐No ☐To Employer ☐Auto Carrier ☐Other: _____

Are you now or have you ever been disabled? (Service or Work)? ☐Yes ☐No When? _____

Have you retained an attorney? ☐Yes ☐No Name & Address: _____

What is your current work status?

☐Full time, no restrictions ☐Full time, restrictions ☐Full time Homemaker ☐Full time student

☐Part time, no restrictions ☐Part time, restrictions ☐Retired ☐Unemployed

☐Off work due to restrictions ☐Other _____

Restrictions: Off work: ☐Yes ☐No ☐Previously From: _____ to _____

Light duty: ☐Yes ☐No ☐Previously (If yes, what are/were your restrictions?) _____

Do/did you require outside help at home?

☐Yes ☐No (If yes, what help do/did you need?) _____

List any accidents or falls and dates: ☐Auto: _____ ☐Recreation: _____

☐Sports: _____ ☐Work Related: _____ ☐Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ☐Yes ☐No Why? _____

Were you ever knocked unconscious? ☐Yes ☐No (If yes, please explain): _____

Have you ever had X-rays taken? ☐Yes ☐No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heal lifts? ☐Yes ☐No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? ☐Yes ☐No _____

OPERATIONS AND PROCEDURES

DATE		DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus	_____	Hernia
_____	Tonsillectomy	_____	Appendectomy	_____	Thyroid	_____	Stomach
_____	Female Organs	_____	Gall Bladder	_____	Back Operation	_____	Rectal Surgery

Other _____ ☐ I have never had any operations or surgeries

Please check the correct box for each item below. Check at least one box for each sign or symptom listed.

Never Previously Presently

GENERAL SYMPTOMS

- ☐☐☐ Allergy(What) ___ _____
- ☐☐☐ Bronchitis
- ☐☐☐ Chills (Constant)
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Headache
- ☐☐☐ Loss of Sleep
- ☐☐☐ Loss of Weight
- ☐☐☐ Nervousness
- ☐☐☐ Night Sweats
- ☐☐☐ Numbness or Pain in arms/legs/hands
- ☐☐☐ Wheezing

MUSCLES & JOINTS

- ☐☐☐ Backache
- ☐☐☐ Foot Trouble
- ☐☐☐ Hernia
- ☐☐☐ Pain Between Shoulders
- ☐☐☐ Painful Tail Bone
- ☐☐☐ Stiff Neck
- ☐☐☐ Spinal Curvature
- ☐☐☐ Swollen Joints
- ☐☐☐ Tremors
- ☐☐☐ Twitching

Never Previously Presently

GASTRO-INTESTINAL

- ☐☐☐ Belching or Gas
- ☐☐☐ Colon Trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Gall Bladder Trouble
- ☐☐☐ Hemorrhoids (piles)
- ☐☐☐ Jaundice
- ☐☐☐ Liver Trouble
- ☐☐☐ Nausea
- ☐☐☐ Stomach Pain
- ☐☐☐ Vomiting
- ☐☐☐ Vomiting Blood
- ☐☐☐ Heart Burn
- ☐☐☐ Bloody Stools
- ☐☐☐ Acid Reflux
- ☐☐☐ Irritable Bowel

CARDIO-VASCULAR

- ☐☐☐ High Blood Pressure
- ☐☐☐ Low Blood Pressure
- ☐☐☐ Chest Pain
- ☐☐☐ Heart Trouble
- ☐☐☐ Poor Circulation
- ☐☐☐ Rapid Heart
- ☐☐☐ Slow Heart
- ☐☐☐ Strokes
- ☐☐☐ Swelling Ankles
- ☐☐☐ Varicose Veins

Never Previously Presently

EYE/EAR NOSE/THROAT

- ☐☐☐ Asthma
- ☐☐☐ Deafness
- ☐☐☐ Earache
- ☐☐☐ Ear Discharge
- ☐☐☐ Ear Noises
- ☐☐☐ Thyroid Problems
- ☐☐☐ Frequent Colds
- ☐☐☐ Hay Fever
- ☐☐☐ Nasal Obstruction
- ☐☐☐ Nose Bleeds
- ☐☐☐ Pain in Eyes
- ☐☐☐ Poor Vision
- ☐☐☐ Blurred Vision
- ☐☐☐ Sinusitis
- ☐☐☐ Sore Throats
- ☐☐☐ Tonsillitis

SKIN OR ALLERGIES

- ☐☐☐ Bruising Easily
- ☐☐☐ Dryness
- ☐☐☐ Eczema
- ☐☐☐ Hives or Allergy
- ☐☐☐ Itching
- ☐☐☐ Sensitive Skin
- ☐☐☐ Skin Eruptions

Never Previously Presently

RESPIRATORY

- ☐☐☐ Chest Pain
- ☐☐☐ Chronic Cough
- ☐☐☐ Difficulty Breathing
- ☐☐☐ Spitting Blood
- ☐☐☐ Spitting Phlegm

GENITO-URINARY

- ☐☐☐ Bed Wetting
- ☐☐☐ Blood in Urine
- ☐☐☐ Frequent Urination
- ☐☐☐ Inability to Control
- ☐☐☐ Urine
- ☐☐☐ Kidney Infection
- ☐☐☐ Kidney Stones
- ☐☐☐ Painful Urination
- ☐☐☐ Prostate Trouble

FOR FEMALES ONLY

- ☐☐☐ Cramps
- ☐☐☐ Hot Flashes
- ☐☐☐ Irregular Cycle
- ☐☐☐ Painful Periods
- ☐☐☐ Vaginal Discharge
- ☐Yes ☐No Pregnant at this Time
- _____ Last Pap Date
- _____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐Appendicitis	☐Anemia	☐Heart Disease	☐Arthritis	☐Pneumonia	☐Measles
☐Goiter	☐Epilepsy	☐Rheumatic Fever	☐Mumps	☐Influenza	☐Mental Disorder
☐Polio	☐Chicken Pox	☐Pleurisy	☐Lumbago	☐Tuberculosis	☐Diabetes
☐Alcoholism	☐Eczema	☐Whooping Cough	☐Cancer	☐Venereal Disease	☐HIV Positive

HABITS

- ☐Smoking Packs/day: _____
- ☐Drinking Alcohol: (Cups/day) _____
- ☐Coffee Cups/Day: _____
- ☐Soft Drink Bottles or Cans/Day: _____
- ☐Water Cups/Day: _____

EXERCISE

- ☐None
- ☐Moderate
- ☐Daily

Type: _____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother(s), # of_____	☐	☐	☐	☐
Sister(s), # of _____	☐	☐	☐	☐

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

Patient Name _____ # _____ Date _____

Please List All Medications that you are currently taking or prescribed

Name of Medication	Strength Prescribed	Dosage Instructions

Please list all allergies to medications that you have.

_____

_____

_____

Please select answers to the following questions

1. What is your race?
   - ☐ White/Caucasian
   - ☐ African American/Black
   - ☐ American Indian/Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian/Pacific Islander
   - ☐ Other _____
   - ☐ Decline to Answer

2. In regards to your ethnicity, are you:
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
   - ☐ Decline to Answer

3. What is your preferred language?
   - ☐ English
   - ☐ Spanish
   - ☐ German
   - ☐ French
   - ☐ Other_____

4. What is your current smoking status?
   - ☐ Current, everyday smoker
   - ☐ Current, some-days smoker
   - ☐ Former smoker
   - ☐ Never smoked
   - ☐ Decline to Answer

5. What is your current tobacco use?
   - ☐ Current, everyday tobacco user
   - ☐ Current, some-days tobacco user
   - ☐ Former tobacco user
   - ☐ Never used tobacco
   - ☐ Decline to Answer