CONFIDENTIAL PERSONAL HEALTH HISTORY

Name:_____ Home Phone:_____
First MI Last
Address:_____Work Phone:_____
City:_____ Mobile/Cell/ _____
State:_____Zip_____E-mail Address:_____
Birthdate:_____ Age:_____ Sex:____M_____F Height:_____Wt:_____
Please check one: ____Student____Single_____Married_____Divorced_____Separated____Widowed
Employer_____Type of Work:_____
Who may we thank for referring you:_____
Spouse's Name:_____ Birthdate:_____
Child's Name:_____ Birthdate:_____
Child's Name:_____ Birthdate:_____
Child's Name:_____ Birthdate:_____
Who is responsible for your bill, You and____Health Ins____Medicare_____Auto Ins____Wkrs/Comp
Method of payment: _____Cash _____Check_____Credit Card _____Debit Card
Our Advertisements you have seen:___Yellow Pages ____TV _____Radio____Newspaper_____Fax/Mailout

CURRENT HEALTH CONDITION

Please list your chief health complaints, symptoms or concerns in the order of their severity:
1._____ How long?_____
2._____ How long?_____
3._____ How long?_____
Is your condition due to:____Auto Accident _____Work Injury _____Gradual Onset _____Unknown ____Other
Date of accident or injury:_____
Who is your primary care physician?_____
Have you seen another Dr. for this condition? A)MD B)Chiropractor C)Osteopath D)Acupuncturist E)Dentist F)Therapist
Dr's Name:_____ Date Consulted_____ Diagnosis_____
Medications You Presently Take: ____Pain Killers ____Muscle Relaxers ____-Anti-inflammatory ____Blood Pressure
___Insulin ___Anti-depressants ___Sleeping Pills ___Aspirin/Similar ___Digestive Aids ___Diet Pills ___Others

In case of an emergency, please give the name of a Relative or close friend not living with you:
Name:_____ Relationship to Patient:_____Home phone#_____
Address:_____Work Phone #_____
City:_____ State:_____Zip:_____

PLEASE READ: I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Clinic will be credited to my account upon receipt. **However,** I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for the payment of these services in full. I. Also, understand that if I suspend or terminate my care in this office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I, also, agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion and it is placed in collections. I direct and assign payment from my insurance company to be made to the doctor.

Patient's Signature:_____Date:_____
Patient or Guardian's Signature Authorizing Care:_____Date:_____

CONFIDENTIAL PERSONAL HEALTH HISTORY (CONT. PAGE 2)

Name: _____ **Date:** _____

PAST HEALTH HISTORY

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can effect your overall course of Your Care.

PLEASE CHECK ANY OF THE FOLLOWING DISEASES OR CONDITIONS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Auto Immune Disease
- ☐ Heart Disease
- ☐ Thyroid
- ☐ HIV Positive
- ☐ Eczema
- ☐ Measles
- ☐ Lumbago
- ☐ Asthma
- ☐ Kidney Stones

PLEASE CHECK THE BOX OF SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS: ☒

THEN CIRCLE THE SYMPTOMS YOU ARE EXPERIENCING AT THE PRESENT TIME: ☐Headaches

MUSCULO-SKELETAL SYSTEM
- ☐ Head Pain / Problems
- ☐ Neck Pain / Problems
- ☐ Shoulder Pain / Problems
- ☐ Arm Pain / Problems
- ☐ Hand Pain / Problems
- ☐ Mid Back Pain / Problems
- ☐ Chest Pain / Problems
- ☐ Stomach Pain / Problems
- ☐ Low Back Pain / Problems
- ☐ Hip Pain / Problems
- ☐ Leg Pain / Problems
- ☐ Foot Pain / Problems
- ☐ Walking Pain / Problems
- ☐ Chewing / Jaw Pain / Problems
- ☐ General Stiffness

NERVOUS SYSTEM
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Muscle Cramping
- ☐ Stress

GENERAL SYSTEM
- ☐ Fatigue
- ☐ Allergies
- ☐ Fever
- ☐ Headaches
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Sinus Headaches
- ☐ Loss of Sleep

GENITO-URINARY SYSTEM
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine
- ☐ Bed-wetting

GASTRO-ENTESTINAL SYSTEM
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas / Bloating After Meals
- ☐ Heartburn / Indigestion
- ☐ Black / Bloody Stool
- ☐ Colitis

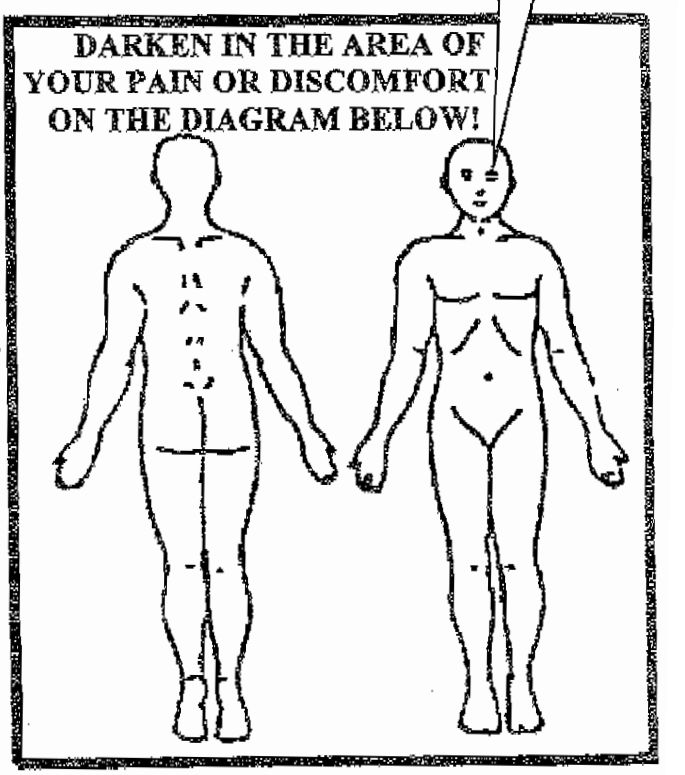
EARS, EYES, NOSE & THROAT
- ☐ Sinus Problems
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Ringing in Ears
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

CARDIO-VASCULAR-RESPIRATORY
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Please do not forget to Draw your pain on me!!!

DARKEN IN THE AREA OF YOUR PAIN OR DISCOMFORT ON THE DIAGRAM BELOW!



Major Surgery or Operations You Have Had: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Heart ☐ Low Back

☐ Neck ☐ Knee ☐ Female ☐ Other: _____ Please Give Dates: _____

Reasons for Hospitalizations (Other Than Above): _____

Thibodaux Chiropractic Clinic
1115 Saint Mary St.
Thibodaux, Louisiana 70301

Electronic Health Records Intake Form

The government now requires us to report on all of this information

First Name:_____ **Last Name:**_____

Email Address:_____@_____

Preferred method of communication for patient reminders (Circle One) Email/ Cell / Home Ph

Preferred Language:_____

Smoking Status (Circle One): Everyday Smoker / Occasional Smoker / Former Smoker/ Never Smoked

Race (Circle One) American Indian or Alaska Native / Asian / Black or African American/ White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline To Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter Meds.)

Medication Name	**Dosage and Frequency** (ex 5 mg once a day)

Do you have any medication allergies?

Medication Name	**Reaction**	**Onset Date**	**Add. Comments**

Do you have; Hypertension_____ **Diabetes Type I**_____ **Diabetes Type II**_____-

I choose to decline receipt of my clinical summary after every visit. *(These summary's are almost always blank due to the nature and frequency of Chiropractic Care).*

Patient Signature:_____ **Date:**_____