Natural Health Care and Family Chiropractic

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Please Print

PERSONAL INFORMATION

NAME____ DATE__________________________________

ADDRESS_____________________________________CITY________________ STATE_______ZIP___________

PHONE______________________SOC. SEC. NO.____________________ DATE OF BIRTH__________________

MARITAL STATUS___________SEX__________AGE_________NUMBER OF CHILDREN__________________

OCCUPATION_____________________________EMPLOYER____

ADDRESS_________________________CITY/ZIP___________________TELEPHONE______________________

NAME OF SPOUSE________________________________ SPOUSE'S OCCUPATION________________________

EMPLOYER____

ADDRESS_________________________CITY/ZIP___________________TELEPHONE______________________

EMERGENCY NOTIFICATION

NAME ____

ADDRESS_________________________CITY/ZIP___________________TELEPHONE______________________

REFERRED BY____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.

Date__________________ Patient's/Parent's Signature____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Natural Health Care and Family Chiropractic to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date__________________ Patient’s/Parent's Signature____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT____

HOW DID IT HAPPEN?____

____

TODAY'S CONDITION STARTED WHEN? ____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?____

WHAT ACTIVITIES LESSON YOUR CONDITION?____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?____

IS THE CONDITION INTERFERING WITH WORK?______ SLEEP?______ ROUTINE? _____________________________

IS CONDITION GETTING PROGRESSIVELY WORSE?____

OTHER DOCTORS SEEN FOR THIS CONDITION?____

TYPE(S) OF TREATMENT____RESULTS?___________________________

HABITS

❑ **ALCOHOL:** TYPE__________________
AMOUNT________________________
❑ **DIET:** SUGAR INTAKE_______________
CARB/STARCH INTAKE______________
FAT INTAKE_____________________
❑ **SMOKING:** PACKS DAILY_____________
❑ HOW LONG_____ ❑ TRIED STOPPING?

❑ **SLEEP ISSUES:**
❑ DIFFICULTY FALLING TO SLEEP?
❑ STAYING ASLEEP?
❑ EARLY MORNING AWAKENINGS
❑ DAYTIME DROWSINESS
❑ STAYING UP LATE NIGHTS
OTHER_______________________

❑ **EXERCISE ROUTINE:**_________________
____
____
❑ **CAFFEINE:** COFFEE CUPS DAILY_________
SODA'S DAILY_______________________
OTHER_____________________________

MEDICATIONS:____

DRUG ALLERGIES:____

MEDICAL HISTORY

❑ Ringing In Ear
❑ Ear Infections - *Frequent*
❑ Dizziness/Fainting
❑ Failing Vision
❑ Eye Infections
❑ Nose Bleeds
❑ Sinus Trouble
❑ Sore Throats - *Frequent*
❑ Hayfever/Allergies
❑ Food Allergies/Sensitivities
Food(s)______________________
Food(s)______________________
❑ Lactose Intolerance
❑ Pneumonia
❑ Bronchitis/Chronic Cough
❑ Asthma/Wheezing
❑ Chest Pain
❑ High Blood Pressure
❑ Heart Murmur
❑ Swollen Ankles
❑ Leg Pain - *Walking*
❑ Varicose Veins/Phlebitis
❑ Loss of Appetite
❑ Difficulty Swallowing
❑ Indigestion or Heartburn
❑ Persistent Nausea/Vomiting

❑ Peptic Ulcers
❑
❑ Abdominal Pain - Chronic
❑ Gall Bladder Trouble
❑ Jaundice/Hepatitis
❑ Change in Bowel Habits
❑ Diarrhea ❑ Constipation
❑ Diverticulitis ❑ Crohn's Colitis
❑ Bloody or Tarry Stools
❑ Hemorrhoids
❑ Hernia
❑ Urine Infections - *Frequent*
Urination Issues: ❑ >Twice Overnight
❑ Painful ❑ Loss Of Control
❑ Decrease in Force/Flow
❑ Blood in Urine
❑ Kidney Stones
❑ Venereal Disease
❑ Urethral Discharge
❑ Chronic Fatigue
❑ Weight Loss - *Recent*
❑ Anemia ❑ Bruise Easily
❑ Cancer
❑ Diabetes
❑ Thyroid Disease
❑ Convulsions/Seizures

❑ Stroke
❑ Tremor/Hands Shaking
❑ Muscle Weakness
❑ Headaches - *Frequent*
❑ Headaches - *Severe/Migraine*
❑ Arthritis/Rheumatism
❑ Osteoporosis
❑ Back Pain - *Recurrent*
❑ Bone Fracture/Joint Injury
❑ Gout
❑ Foot Pain ❑ Cold Numb Feet
❑ Rashes ❑ Hives
❑ Psoriasis ❑ Eczema
❑ Nervousness ❑ Anxiety
❑ Depression
❑ Add ❑ ADHD
❑ Memory Loss
❑ Moodiness - *Excessive*
❑ Phobias
❑ Mental Illness
❑ Prostate Disease
❑ Sexual/Menstrual Dysfunction
❑ Frequent Infections
❑ Diphtheria
❑ Tetanus
❑ Chicken Pox ❑ Polio ❑ Mumps

❑ Measles ❑ Rubella ❑ Herpes
❑ Tuberculosis ❑ Rheumatic Fever
❑ Other_______________________
❑ Other_______________________

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow: ❑ Regular
❑ Irregular ❑ Pain/Cramps
___Days of Flow _____ Cycle Length
_______ Date - 1st Day of Last Period
❑ Pain/Bleeding During or After Sex
Number of:
____Pregnancies ___ Live Births
____Miscarriages ___ Abortions
Birth Control Method___________
Birth Control Pill______________
❑ Flushing / Menopause
Date of Last PAP Test____________
❑ Normal ❑ Abnormal
Date of Last Breast Exam/Mammogram________________
❑ Normal ❑ Abnormal

HOSPITALIZATIONS:

DATE	REASON	DATE	REASON

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS AND SISTERS	______ ______ ______	______ ______ ______	______ ______ ______
SPOUSE			
CHILDREN	______ ______ ______	______ ______ ______	______ ______ ______

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

ILLNESS	FAMILY MEMBER
DIABETES	
CANCER	
BLOOD DISEASE	______
GLAUCOMA	______
EPILEPSY	______
RHEUMATOID ARTHRITIS	
TUBERCULOSIS	______
GOUT	______
HIGH BLOOD PRESSURE	______
HEART DISEASE	
BACK PROBLEMS	