



Date	I.D. #
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Patient Health History

Name: _____

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

Address: _____ City: _____

State: _____ Zip: _____

Phone Numbers:

(Home): _____ (Work): _____ (Cell): _____ (Fax): _____

Email Address: _____

I give you permission to email me appointment reminders, special offers, newsletters, birthday cards, etc. Yes No

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: _____

Past Chiropractic Care: Yes No When? _____

Chiropractic Doctor's Name: _____ Results: _____

Medical Doctor's Name: _____

I give you permission to send my Medical Doctor a report regarding my chiropractic care. Yes No

I give you permission to place my name on the referral board or computer screens in the office for referring patients to this office.

Thank you in advance. Yes No

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 heel 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 _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?

(Please list) _____

OPERATIONS AND PROCEDURES

I have never had any operations or surgeries

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

Other: _____

Please check the correct box for each item below.

Check at least one box for each sign or symptom listed. Never Previously Presently

Never Previously Presently	Never Previously Presently	Never Previously Presently	Never Previously Presently
GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	RESPIRATORY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy(What) _____ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills (Constant)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Noises	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids (piles)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Colds	GENITO-URINARY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed Wetting
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in Urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Infection
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness or Pain in arms/legs/hands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Burn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blurred Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Stones
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloody Stools	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinusitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Urination
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acid Reflux	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore Throats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate Trouble
MUSCLES & JOINTS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Backache	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR FEMALES ONLY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruising Easily	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or Allergy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Periods
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stiff Neck	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this Time
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen Joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin Eruptions	_____ Last Pap Date
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Strokes		_____ Last Menstrual Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twitching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling Ankles		
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose Veins		

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

- | | | | | | |
|---------------------------------------|--|--|------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Mental Disorder | | | | |

HABITS

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

FAMILY HISTORY

- | | Diabetes | Kidney | Cancer | Back | Heart |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brother(s), # of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sister(s), # of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

EXERCISE: None Moderate Daily Type: _____

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/will not* 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 responsible for payment, regardless of insurance coverage. 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 understand that any unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of \$15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payors and to secure the payment of benefits.

I hereby authorize the doctor to examine and treat my condition as he/she 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.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____