

CONFIDENTIAL PATIENT HISTORY

Date: _____

Patient # _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? yes no

Occupation _____ Employer _____

Spouse's Name _____ D.O.B _____ Spouse Ph _____ Employer _____

Children's Name & Ages _____

Have you had previous Chiropractic care? yes no Whom? _____

Who may we thank for referring you to our office? _____ Walk In Advertisement Promotion Yellow Pages

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

When doctors work together, it benefits you. May we update your medical doctor regarding your treatment in our office? yes no

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ How Did it begin: _____

How often do you experience these symptoms? Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%

Have you ever experienced the same or similar symptoms? yes no When? _____

Have you been to another doctor for this problem? yes no Who/Where? _____

Type of Pain: Sharp Dull Ache Burn Throb Other Do you have Numbness or Tingling? yes no Where? _____

Does the Pain Radiate into: Arm Hand Leg Foot Other _____ Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Drugs you now take: Nerve Pills Pain Pills Muscle Relaxer Blood Pressure Other: _____

Do any family members suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ How Did it begin: _____

How often do you experience these symptoms? Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%

Have you ever experienced the same or similar symptoms yes no When? _____

Have you been to another doctor for this problem? yes no Who/Where? _____

Type of Pain: Sharp Dull Ache Burn Throb Other Do you have Numbness or Tingling? yes no Where? _____

Does the Pain Radiate into: Arm Hand Leg Foot Other _____ Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Age of Mattress _____ Comfortable Uncomfortable

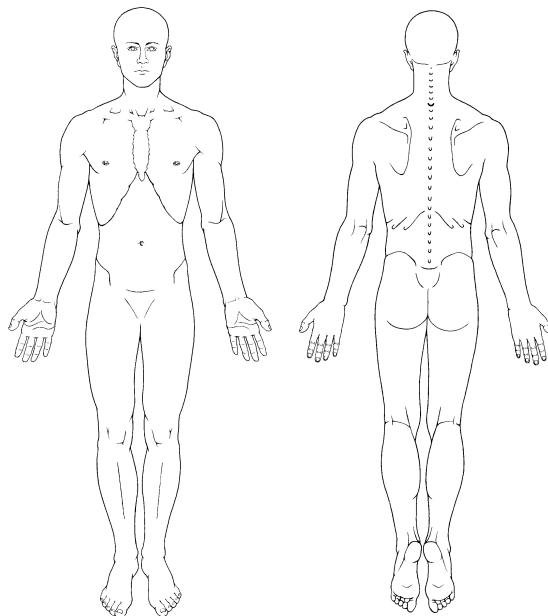
Have you ever been in an auto accident? Past Year Past 5 Years Over 5 Years Never

Please describe: _____

Please list all surgeries, injuries, accidents, falls, etc: _____

Please mark off all areas of complaint on the diagrams with the following indicators:

- AAA=ache
- DDD=dull
- NNN = numbness
- TTT= tingling
- BBB= burning
- SSS=sharp/stabbing
- XXX = other



Please list any medications or vitamins you are currently taking (including dosage).

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ♦♦♦ 1 ♦♦♦ 2 ♦♦♦ 3 ♦♦♦ 4 ♦♦♦ 5 ♦♦♦ 6 ♦♦♦ 7 ♦♦♦ 8 ♦♦♦ 9 ♦♦♦ 10

Do you smoke? yes no If yes, how many packs per week? _____ Have you ever smoked in the past? yes no When did you quit? _____

Do you consume alcohol? yes no If yes, how many drinks per week? _____

Do you consume caffeine? yes no If yes, how many drinks per day? _____

Do you exercise? yes no If yes, how many times per week and what type? _____

Do you have a high stress level? yes no If yes, list reasons: _____

Is there any possibility that you may be pregnant? yes no Date of Last Menstrual Cycle _____

Please check if you have had any of the following:

<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Midback Pain
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Arm/Leg Pain	<input type="checkbox"/> Jaw Pain/Clicking
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Allergies	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Nervousness	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Heart Disease/Problems
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> PMS/Cramps	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Discover Chiropractic* will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Discover Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____