

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)		Have you consulted a chiropractor before? <input type="radio"/> No <input type="radio"/> Yes		Patient Number (office use only)	
Whom may we thank for referring you?		When?		If so, whom?	
Age	Gender <input type="radio"/> Male <input type="radio"/> Female	Race <input type="radio"/> American Indian <input type="radio"/> Alaskan Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> Other <input type="radio"/> White <input type="radio"/> Decline to answer		Ethnicity <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Decline to specify	
Birth Date (MM/DD/YYYY)		Your Last Name		Your Social Security Number	
Your First Name		Your Middle Name (or Initial)		Smoking Status (age 13 and over) <input type="radio"/> Never A Smoker <input type="radio"/> Former Smoker <input type="radio"/> Current Every Day Smoker <input type="radio"/> Current Some Day Smoker <input type="radio"/> Heavy Smoker <input type="radio"/> Light Smoker	
Address		City		State/Province	
Home Phone		Cell Phone		ZIP/Postal Code	
Email Address		Emergency Contact		Emergency Contact's Phone	
Your Occupation		Your Employer		Address	
Your Employer		Address		City	
Primary Care Provider's Name		Insurance Carrier		Policy Number	
Insurance Carrier		Insured's Last Name		Birth Date (MM/DD/YYYY)	
Insured's First Name		Insured's Middle Name (or Initial)		Who carries this policy? <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent	
Insured's Employer		Address		City	
Address		City		State/Province	
City		State/Province		ZIP/Postal Code	
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City		State/Province		ZIP/Postal Code	
City		State/Province		ZIP/Postal Code	
City					

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
 An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
 An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Additional Complaint
The additional symptom that prompted me to seek care today is: _____

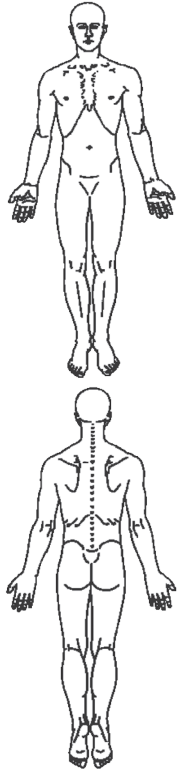
And are the result of (darken circle):
 An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____



1. What else should Dr. Kirgis know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had <input type="radio"/> Have <input type="radio"/> Osteoporosis	Had <input type="radio"/> Have <input type="radio"/> Arthritis	Had <input type="radio"/> Have <input type="radio"/> Scoliosis	Had <input type="radio"/> Have <input type="radio"/> Neck pain	Had <input type="radio"/> Have <input type="radio"/> Back problems	Had <input type="radio"/> Have <input type="radio"/> Hip disorders	NONE <input type="radio"/>
<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	Initials _____

b. Neurological

Had <input type="radio"/> Have <input type="radio"/> Anxiety	Had <input type="radio"/> Have <input type="radio"/> Depression	Had <input type="radio"/> Have <input type="radio"/> Headache	Had <input type="radio"/> Have <input type="radio"/> Dizziness	Had <input type="radio"/> Have <input type="radio"/> Pins and needles	Had <input type="radio"/> Have <input type="radio"/> Numbness	NONE <input type="radio"/>
						Initials _____

c. Cardiovascular

Had <input type="radio"/> Have <input type="radio"/> High blood pressure	Had <input type="radio"/> Have <input type="radio"/> Low blood pressure	Had <input type="radio"/> Have <input type="radio"/> High cholesterol	Had <input type="radio"/> Have <input type="radio"/> Poor circulation	Had <input type="radio"/> Have <input type="radio"/> Angina	Had <input type="radio"/> Have <input type="radio"/> Excessive bruising	NONE <input type="radio"/>
						Initials _____

d. Respiratory

Had <input type="radio"/> Have <input type="radio"/> Asthma	Had <input type="radio"/> Have <input type="radio"/> Apnea	Had <input type="radio"/> Have <input type="radio"/> Emphysema	Had <input type="radio"/> Have <input type="radio"/> Hay fever	Had <input type="radio"/> Have <input type="radio"/> Shortness of breath	Had <input type="radio"/> Have <input type="radio"/> Pneumonia	NONE <input type="radio"/>
						Initials _____

e. Digestive

Had <input type="radio"/> Have <input type="radio"/> Anorexia/bulimia	Had <input type="radio"/> Have <input type="radio"/> Ulcer	Had <input type="radio"/> Have <input type="radio"/> Food sensitivities	Had <input type="radio"/> Have <input type="radio"/> Heartburn	Had <input type="radio"/> Have <input type="radio"/> Constipation	Had <input type="radio"/> Have <input type="radio"/> Diarrhea	NONE <input type="radio"/>
						Initials _____

f. Sensory

Had <input type="radio"/> Have <input type="radio"/> Blurred vision	Had <input type="radio"/> Have <input type="radio"/> Ringing in ears	Had <input type="radio"/> Have <input type="radio"/> Hearing loss	Had <input type="radio"/> Have <input type="radio"/> Chronic ear infection	Had <input type="radio"/> Have <input type="radio"/> Loss of smell	Had <input type="radio"/> Have <input type="radio"/> Loss of taste	NONE <input type="radio"/>
						Initials _____

g. Skin

Had <input type="radio"/> Have <input type="radio"/> Skin cancer	Had <input type="radio"/> Have <input type="radio"/> Psoriasis	Had <input type="radio"/> Have <input type="radio"/> Eczema	Had <input type="radio"/> Have <input type="radio"/> Acne	Had <input type="radio"/> Have <input type="radio"/> Hair loss	Had <input type="radio"/> Have <input type="radio"/> Rash	NONE <input type="radio"/>
						Initials _____

Patient name

Patient Number
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Doctor's Initials

Whitley Chiropractic & Wellness Center
Drs. Jamie & Lori Kirgis

(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

Initials _____

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

Initials _____

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE

Initials _____

Patient name _____

Patient Number (office use only) _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL	4. Illnesses Check the illnesses you have Had in the past or Have now.	5. Operations Surgical interventions, which may or may not have included hospitalization.	6. Treatments Check the ones you've received in the Past or are receiving Currently .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	Past <input type="radio"/> Currently <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	7. Allergies Are you allergic to any medications?	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	Yes <input type="radio"/> No <input type="radio"/> If Yes please list: _____	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma		<input type="radio"/> Homeopathy
Had <input type="radio"/> Have <input type="radio"/> Goiter		<input type="radio"/> Hormone replacement	
Had <input type="radio"/> Have <input type="radio"/> Gout		<input type="radio"/> Inhaler	
Had <input type="radio"/> Have <input type="radio"/> Heart disease		<input type="radio"/> Massage therapy	
Had <input type="radio"/> Have <input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy	
Had <input type="radio"/> Have <input type="radio"/> HIV Positive		<input type="radio"/> Medications	
Had <input type="radio"/> Have <input type="radio"/> Malaria		(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____	
Had <input type="radio"/> Have <input type="radio"/> Measles		_____	
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis		_____	
Had <input type="radio"/> Have <input type="radio"/> Mumps		_____	
Had <input type="radio"/> Have <input type="radio"/> Polio	8. Injuries Have you ever...	<input type="radio"/> Used a crutch or other support	
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used neck or back bracing	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Received a tattoo	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Had a body piercing	
Had <input type="radio"/> Have <input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident		

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Kirgis about the health of your immediate family members.

	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
FAMILY	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Kirgis about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials _____

Whitley Chiropractic & Wellness Center
Dr. Jamie & Lori Kirgis

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only)

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consultation Notes

Doctor's Initials _____

**Whitley Chiropractic
& Wellness Center
Drs. Jamie & Lori Kirgis**

Patient (or Guardian's) signature

Date (MM/DD/YYYY)