PEARCE CHIROPRACTIC, INC.

DR. NANCY J. PEARCE, D.C.

CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Birth Date: ____/____/_____ Age: ____ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (_____)_____ Cell # (_____)_____ Work # (_____)_____

Single Married Divorced Widow Partner No. of Children: ____ Email: _____

Occupation: _____ Employer: _____ Social Security #_____-____-_____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Spouse's Work Phone: (_____)_____

How did you learn of Dr. Pearce? _____

Past Chiropractic Care: ☐YES ☐NO When?_____ Doctor's Name:_____

Treated for? _____ Results: _____

Nearest relative or close friend if we need to leave you a message: _____

Their # (___)____-_____ Who is responsible for payment? SELF ☐ SPOUSE☐ OTHER☐

If other, please explain: _____

PRESENT HEALTH

Purpose of this appointment: _____

Date of Illness: _____ Time: _____ ☐AM ☐PM Location: _____

Chief Complaints: 1. _____

2. _____

3. _____

4. _____

Are your problems due to an injury? ☐NO ☐YES ☐On the Job ☐Auto Accident ☐Personal Injury ☐ Other

Please list any accidents EVER:

Motor Vehicle:_____

Falls:_____

Sports:_____

Broken bones or dislocations:_____

Ever been on crutches? ☐NO ☐YES Spinal Taps or Injections? ☐NO ☐YES Been knocked unconscious? ☐NO ☐YES

Ever had a lapse of memory? ☐NO ☐YES Ever had x-rays, MRI or CT scan? ☐NO ☐YES When?_____ Why?_____

Have you made a report of your accident? ☐NO ☐YES ☐To Employer ☐Auto Carrier ☐Other

Has the accident been reported? ☐NO ☐YES ☐Workers Comp ☐Auto Carrier ☐Other

Are you now or have you ever been disabled? [Service] or [Work]? ☐NO ☐YES When?_____

Have you retained an attorney? ☐NO ☐YES; Name & Address: _____

Other Doctors seen for this condition: _____

List your current Medications: _____

Have you been treated for any health condition in the last year? ☐NO ☐YES; If yes, please explain: _____

_____

How often do you visit the dentist?_____ How often do you floss?_____ How many of the following do you have: Fillings? _____ Root Canals?_____ Bridges? _____ Do you wear dentures? ☐NO ☐YES

HABITS

☐Smoking Packs/Day____
☐Drinking Drinks/Day____
☐Coffee Cups/Day____
☐Soda Cans/Day____

EXERCISE

☐None
☐Rarely
☐Moderate
☐Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Stroke	Back
Mother						
Father						
Brothers						
Sisters						

PROCEDURES AND OPERATIONS

Date		Date		Date	
_____	Tonsillectomy	_____	Appendectomy	_____	Sinus
_____	Gall Bladder	_____	Tubes in Ears	_____	Thyroid
_____	Vaccinations	_____	Female Organs	_____	Hernia
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Heart	_____	Cataract Surgery	_____	Other_____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐541 Appendicitis
☐541 Pneumonia
☐541 Rheumatic Fever
☐541 Polio
☐541 Tuberculosis
☐541 Whooping Cough

☐285.9 Anemia
☐285.9 Measles
☐285.9 Mumps
☐285.9 Chicken Pox
☐285.9 Diabetes
☐285.9 Cancer

☐429.9 Heart Disease
☐429.9 Goiter
☐429.9 Influenza
☐429.9 Pleurisy
☐429.9 Alcoholism
☐429.9 Venereal Disease

☐716.9 Arthritis
☐716.9 Epilepsy
☐716.9 Mental Disorder
☐716.9 Lumbago
☐716.9 Eczema
☐ - AIDS

Circle "1" - Previously Had; Circle "2" - Currently Have; (Leave Blank if never experienced)

General Symptoms

1 2 784.0 Headache
1 2 780.6 Fever
1 2 780.9 Chills
1 2 780.8 Night Sweats
1 2 780.2 Fainting
1 2 780.4 Dizziness
1 2 780.3 Convulsions
1 2 784.52 Loss of Sleep
1 2 780.7 Fatigue
1 2 799.2 Nervousness
1 2 783 Loss of Weight
1 2 782 Numbness or pain In arms/ legs/ hands
1 2 995.3 Allergy
1 2 786.09 Wheezing
1 2 729.2 Neuralgia

Eye/Ear/Nose/Throat

1 2 368.9 Poor Vision
1 2 378.9 Crossed Eyes
1 2 379.91 Pain in Eyes
1 2 389.9 Deafness
1 2 388.7 Earache
1 2 388.3 Ear Noise
1 2 388.6 Ear Discharges
1 2 478.1 Nasal Obstruction
1 2 784.7 Nose Bleeds
1 2 462 Sore Throats
1 2 784.49 Hoarseness
1 2 477.9 Hay Fever
1 2 493.9 Asthma
1 2 460 Frequent Colds
1 2 240.9 Enlarged Thyroid
1 2 463 Tonsillitis
1 2 686.9 Sinus Trouble

Genito-Urinary

1 2 788.3 Frequent Urination
1 2 788.1 Painful Urination
1 2 599.7 Blood in Urine
1 2 592 Kidney Infection
1 2 788.3 Bed Wetting
1 2 788.1 Prostate Trouble
1 2 601.9 Inability to control urine

Respiratory

1 2 786.2 Chronic Cough
1 2 786.3 Spitting Blood
1 2 933.1 Spitting Phlegm
1 2 786.5 Chest Pain
1 2 786.09 Difficulty Breathing

Gastro-Intestinal

1 2 783 Poor Appetite
1 2 536.8 Poor Digestion
1 2 994.2 Excessive Hunger
1 2 787.3 Belching or Gas
1 2 787 Nausea
1 2 787 Vomiting
1 2 578 Vomiting Blood
1 2 536.8 Pain over Stomach
1 2 564 Constipation
1 2 558.9 Diarrhea
1 2 789 Colon Trouble
1 2 455.6 Hemorrhoids/ Piles
1 2 785.1 Liver Trouble
1 2 782.4 Jaundice
1 2 575.9 Gall Bladder Trouble

Cardio-Vascular

1 2 783 Rapid Heart
1 2 427.89 Slow Heart
1 2 401.9 High Blood Press.
1 2 458.9 Low Blood Press.
1 2 786.51 Pain over Heart
1 2 438 Past Heart Trouble
1 2 719.07 Swelling Ankles
1 2 759.9 Poor Circulation
1 2 - Varicose Veins
1 2 436 Strokes

Skin or Allergies

1 2 368.9 Skin Eruptions
1 2 698.9 Itching
1 2 278.8 Bruising Easily
1 2 701.1 Dryness
1 2 - Boils
1 2 782 Sensitive Skin
1 2 708.9 Hives/Allergy
1 2 692.9 Eczema

Muscles & Joints

1 2 - Weakness
1 2 - Twitching
1 2 847 Stiff Neck
1 2 722.10 Backache
1 2 719 Swollen Joints
1 2 781 Tremors
1 2 729.5 Foot Trouble
1 2 724.79 Painful Tail Bone
1 2 724.5 Pain Between Shoulders
1 2 563.3 Hernia
1 2 737.3 Spinal Curvature

For Women Only

1 2 786.2 Painful Periods
1 2 626.6 Excessive Flow
1 2 626.4 Irregular Cycle
1 2 627.2 Hot Flashes
1 2 625.3 Cramps/ Backache
1 2 634.9 Miscarriage
1 2 623.5 Vaginal Discharge
1 2 - Pregnant Now!
__/__/__ Date of Last Pap Smear