Garrity Chiropractic Patient History Form

Name: ______________________________________________________________________________

Address: ____________________________________________________________________________

City: ________________________________________ State: __________ Zip: ____________________

Home Phone: ______-_______-_______Work Phone: ______-______-________ Cell Phone: ______-______-__________

What number do you prefer we reach you at? ☐ Home ☐ Work ☐ Cell

Email Address: ________________________ Occupation: ____________________________________

Date of Birth: ____________________ Social Security #: ________-_______-________ Gender: Male - Female

Preferred language_________________ Race Ethenicity__________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Name of Insurance Company**: ______________________________________________________________

Policy #: ____________________________________ Group #__________________________________

Policy Holders Name: ___________________________________________ DOB:____________________

Social Security #: ________-________-_________

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _______________________

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist/Hand

☐ Other: __________________________________________________________________________

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: ___________________________________________________________

List all **Medications** you are currently taking: (Example: Ibuprofen – Pain)

_________________________________________ _________________________________________

_________________________________________ _________________________________________

_________________________________________ _________________________________________

**Are you allergic to any medications:** ☐ No ☐Yes ______________________________________________

**List your Family History:**

 Arthritis  Asthma  Back Pain  Cancer  Depression  Diabetes  Epilepsy  Genetic Spinal Condition

 High Blood Pressure  Heart Problems  Multiple Sclerosis  Neurological Problems  Parkinson's  Polio

 Prostate Problems  Stroke/Heart Attack

Please list all family members who had/has any of the problems above: Example: Grandmother – High blood pressure

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Have you had any auto or other accidents in the past?  No Yes

Describe: ____________________________________________________________

What was date of last physical examination: ____________________________________________

Do you smoke?  No Yes –How many per day? ______________ If no were you a former smoker?  No Yes

Do you drink alcohol?  No Yes - how many per day? ____________

Do you drink caffeine?  No Yes - how many per day? ____________

Do you exercise?  No Yes (what forms and how often): ______________________________

Do you have any disabilities?  No Yes (if yes please explain)__________________________

How is your diet? ________________________________________________

Sleep Habits  Good Bad (how many hours per night) ___________________________

Do you feel safe at home?  No Yes ___________________________

Do you have stress?  Work Home  None other ___________________________

Are you currently  Employed  High School  College  Other ______________________

Have you ever had chiropractic care?  Yes  No Where?_____________________________

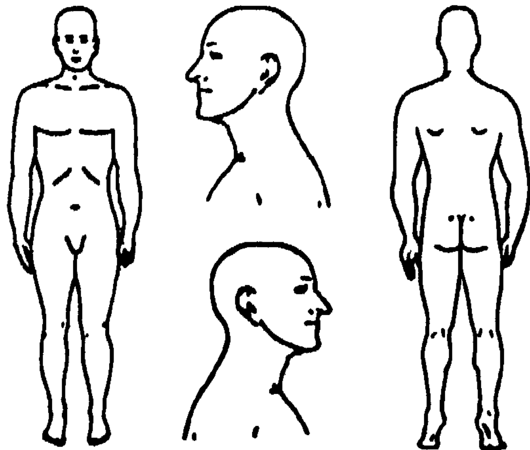
Why? _________________________ When was your last visit?______________

Were X-Rays taken?  Yes  No

OFFICE USE ONLY

| Blood Pressure | Pulse | Height | Weight | Temperature |
|---|---|---|---|---|
| | | | | |

***PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW***



Main reason for consulting the office:

-  Become pain free
-  Explanation of my condition
-  Learn how to care for my condition
-  Reduce symptoms
-  Resume normal activity level

What is your major complaint? ___________________________________Date problem began? ______________________

How did this problem begin (falling, lifting, etc.)? ____________________________________________________________

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

 Constantly (76-100% of the day)  Frequently (51-75% of the day)

 Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Describe the nature of your symptoms:  Sharp  Dull  Numb  Burning  Shooting  Tingling  Radiating Pain

 Tightness  Stabbing  Throbbing  Other: ______________________________________________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

 1  2  3  4  5  6  7  8  9  10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities)  1  2  3  4  5  6  7  8  9  10

What activities aggravate your condition (working, exercise, etc)? _______________________________________________

What makes your pain better (ice, heat, massage, etc)? _________________________________________________________

What is your **SECOND** complaint? ___________________________________Date problem began? ______________________

How did this problem begin (falling, lifting, etc.)? ____________________________________________________________

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

 Constantly (76-100% of the day)  Frequently (51-75% of the day)

 Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ______________________________________________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ________________________________________________

What makes your pain better (ice, heat, massage, etc)? __________________________________________________________

What is your next complaint? __________________________________Date problem began? ______________________

How did this problem begin (falling, lifting, etc.)? ____________________________________________________________

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ______________________________________________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ________________________________________________

What makes your pain better (ice, heat, massage, etc)? __________________________________________________________

## ASSIGNMENT OF BENEFITS – AUTHORIZATION TO RELEASE INFORMATION – FINANCIAL RESPONSIBILITY

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Dr. Gregory Garrity.

This order will remain in effect until revoked by me in writing. A photo copy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignment to release all information necessary to secure payment and to complete disability forms presented to me.

Signed________________________________________Date________