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.

Miller Spinal Health and Wellness Center Guy Bradford Miller, D.C. 404 South Court Street Marion, IL 62959 www.millerhealthcenter.com info@millerhealthcenter.com

Today's Date (MM/DD/YYYY)	Ha	ive you consulted a chiropractor befo	re? Patient	Number (office use only)
		No O Yes		
Whom may we thank for referring you?		When?	If so, whom?	
Gender		Race		Ethnicity
Age OMale OF	emale		◯ Asian ◯ Black or African American ander ◯ Other ◯ White	•
Birth Date (MM/DD/YYYY)		O Decline to answer		O Decline to specify
Your Last Name		Your Social Security Number	Smoking Status (age 13 and ove	
Tour Last Name		Tour Social Security Number	○ Never A Smoker○ Former Smoker○ Current Every Day Smoker○ Cu	
Your First Name		Your Middle Name (or Initial)	— ○ Heavy Smoker ○ Light Smoker	
Address			Marital Status Married	
			○ Single ○ Divorced	
City	State/Provi	nce ZIP/Postal Code	─ ○ Widowed ○ Separated Pre	eferred Language
Home Phone	Cell Phone		Spouse's Name	
Email Address			Child's Name and Age	
Emergency Contact	Emergency	Contact's Phone	Child's Name and Age	
Your Occupation			Child's Name and Age	2
Your Employer			Work Phone	CONFIDENTIAL
Address			May we contact you at work?	DE
			○ Yes ○ No	4
City	State/Provi	nce ZIP/Postal Code	Preferred method of contact? O Home Phone O Cell Phone	Έ
Primary Care Provider's Name			_ ○ Work Phone ○ Email	[
Insurance Carrier		Policy Number		HEALTH
Insured's Last Name		Birth Date (MM/DD/YYYY	Who carries this policy? Self Spouse Parent	
Insured's First Name	Insured's M	liddle Name (or Initial)	- Sein Spouse Statent	ÖR
Insured's Employer				INFORMATION
Address				<u>Q</u>
City	State/Provi	nce ZIP/Postal Code	Employer's Phone	Version No. 130984059 Q 2015 Paperwork Project. All rights reserved.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply. Location (Where does it hurt?) **Primary Complaint** Secondary Complaint Additional Complaint Circle the area(s) on the The primary symptom that prompted me to seek care The secondary symptom that prompted me to seek care The additional symptom that prompted me to seek care illustration. today is: "0" for current condition "X" for conditions experienced in the past And are the result of (darken circle): And are the result of (darken circle): And are the result of (darken circle): An accident or injury An accident or injury An accident or injury ○ Work ○ Auto ○ Other ○ Work ○ Auto ○ Other ○ Work ○ Auto ○ Other A worsening long-term problem A worsening long-term problem A worsening long-term problem ○ An interest in: ○ Wellness ○ Other ___ OAn interest in: Wellness Other ___ An interest in: Wellness Other Onset (When did you first notice your current Onset (When did you first notice your current Onset (When did you first notice your current symptoms?) symptoms?) symptoms?) **Prior interventions** (What have you done to relieve Prior interventions (What have you done to relieve Prior interventions (What have you done to relieve the symptoms?) the symptoms?) the symptoms?) O Prescription medication O Acupuncture O Prescription medication O Acupuncture O Prescription medication O Acupuncture Chiropractic Over-the-counter drugs Chiropractic Over-the-counter drugs Chiropractic Over-the-counter drugs Homeopathic remedies Massage Homeopathic remedies Massage Homeopathic remedies Massage O Physical therapy O Physical therapy O Physical therapy O Ice O Ice O Ice O Heat O Heat O Heat Surgery Surgery Surgery Other __ Other __ Other __ 1. What else should Dr. Miller 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 NONE (O Osteoporosis Arthritis O Scoliosis O Neck pain O Back problems O O Hip disorders ○ Knee injuries ○ ○ Foot/ankle pain ○ ○ Shoulder problems ○ ○ Elbow/wrist pain ○ ○ TMJ issues ○ Poor posture Initials b. Neurological Had Have Had Have Had Have Had Have NONE (Anxiety O Depression O Headache O Dizziness 0 O Pins and Numbness needles Initials c. Cardiovascular Had Have Had Have Had Have Had Have Had Have Had Have NONE 🔾 O O Low blood O High blood O High cholesterol O O Poor circulation O O Angina O Excessive Patient name pressure pressure bruising Initials ____ d. Respiratory NONE (Had Have O O Asthma O O Apnea O Emphysema O O Hay fever O Shortness O Pneumonia **Patient Number** Initials (office use only) e. Digestive Had Have Had Have NONE (O Anorexia/bulimia O O Ulcer ○ Food sensitivities ○ ○ Heartburn O Constipation O Diarrhea \bigcirc **Doctor's Initials** Initials _____ f. Sensory Had Have Had Have Had Have Had Have NONE (Miller Spinal Health O O Blurred vision O O Ringing in ears O \circ O Hearing loss O Chronic ear O C Loss of smell O Loss of taste and Wellness Center Initials _ infection g. Skin Guy Bradford Miller, D.C. Had Have Had Have NONE (O Skin cancer O O Psoriasis O Eczema O Acne O Hair loss O Rash

Initials

(C	ontinued from previou	s page)												
Ha	Endocrine ad Have Thyroid issues Genitourinary	Had H	lave O Immune disorders		Have	Had	Have			Have Swollen glands		Have O Low energy	NONE O	Patient name
Ha	Ad Have C Kidney stones	Had H	lave O Infertility		Have O Bedwetting	Had	Have			Have O Erectile dysfunction		Have O PMS symptoms	NONE O	Patient Number (office use only)
Ha	Constitutional ad Have Fainting	Had H	lave Low libido		Have Poor appetite		Have		Had (Have Sudden weigh gain/loss (circle	t ()	Have	NONE O	All other systems negative
Pas Plea	et Personal, Family use identify your past he	and So	ocial History story, including ac	cidents	, injuries, illnesses and	I trea	tmen	ts. Please comple	te ea	· ·	5 0110)		miliais	
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9. F	O O Scarle	natic fev t fever ly trans	ver mitted disease	000	uries ou ever Had a fractured or brok Had a spine or nerve d Been knocked unconso Been injured in an acci	isord	ler	_	k or a tat					Consultation Notes
	ne health issues are her	-			health of your immedia	te far	nily r	members.						
FAMILY	Mother Father Sister 1 Sister 2 Brother 1 Brother 2			d Poo								Natu		
10.	Are there any other	r hered	litary health iss	ues tl	nat you know about?									
11.	Social History	oolth L	hito and street	volc.										
iell	Coffee use	Daily Daily	○ Weekly H	ow mu	ch?					Prayer or med	stress	s? Yes	○No ○No	
SOCIAL	Exercising C	Daily	○Weekly H	ow mu	ch? ch? ch?					Financial peac Vaccinated? Mercury filling		○ Yes○ Yes○ Yes	○No ○No ○No	Doctor's Initials Miller Spinal Health and Wellness Center
S	Soft drinks C	-	-		ch?					Recreational d	rugs'	? Yes	○ No	Guy Bradford Miller, D.C.

Hobbies: _

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Patient Numbic (office sea enewly) Patient Numbic (office sea ene	Sitting —	No Effect	Mild Effect	Moderate Effect	Severe Effect	Grocery shopping ————	No Effect	Mild Effect	Moderate Effect	Severe Effect	Patient name
Celtron use soley) Walking Malking Ma	9	•	_								Patient Numbe
Walking	•	_	_				0	\circ			(office use only)
Showering or bathing Dressing myself Climbing slairs Love life Getting in size Getting	· ·	_	_		$\overline{}$		_	_			
Dressing myself Dressing myself Dressing myself	•	_	_			•	_	_			
Climbing stairs		_	_			0 0	_	•			
Using a computer	-	_	_				_	_			
Staying asleep———————————————————————————————————	-	_	_				Ŭ	_			
Concentrating Concentration Concentrating Concentration Co	- '	_	_	_			_	_	_		
Looking over shoulder	-	_	_	_	_		_	_	_		
Caring for family	-	_	_	_	_	· ·	_	_	_		
What is the type and approximate age of your mattress and pillow?	=	_	_	_	-	<u> </u>	•	_	_	_	
Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals What would be the most significant thing that you could do to improve your health? In addition to the main reason for your visit today, what additional health goals do you have? In addition to the main reason for your visit today, what additional health goals do you have? 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. 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. 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): 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. 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. To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the	What is the major stress	sor in your life?	?			14. How much sleep	do you averag	e per nigh	it?	Hours	
Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals What would be the most significant thing that you could do to improve your health? In addition to the main reason for your visit today, what additional health goals do you have? In addition to the main reason for your visit today, what additional health goals do you have? 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. 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. 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): 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. 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. To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the										_	
What would be the most significant thing that you could do to improve your health? In addition to the main reason for your visit today, what additional health goals do you have? Dowledgements 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. 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. 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. 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): 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. 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.	What is the type and app	proximate age	of your m	nattress an	d pillow?	16. What is your p	reterred sleepi	ng positio	n?		
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Date (MM/DD/YYYY)

Patient (or Guardian's) signature

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Guy Bradford Miller, D.C.