COMPREHENSIVE PATIENT HISTORY

Patient # __________ Date ________

Welcome to our office. Please complete all questions. Thank you.

Name: ____________________ Date: __________

Address: ____________________ City: __________ State: _____ Zip: __________

Home Phone: __________ Work Phone: __________ Cell: __________ Email: __________

Date of Birth: __________ Age: ______ Sex: _________ Social Security Number: __________

Marital Status: □ M □ S □ D □ W Spouse's Name: __________ Children? □ Yes □ No Ages: __________

Employed By: ____________________ Occupation: __________

Address: ____________________ City: __________ State: _____ Zip: __________

Do you receive mail at work? □ Yes □ No

In case of emergency, please notify: ____________________ Phone: __________

Who can we thank for referring you to our office? ____________________

□ Verizon Super Pages □ Yellow Book □ Mailing □ Advertisement □ Web Site □ Other__________

Previous Chiropractic care: □ Yes □ No Dr.__________ Length of time under care______ Last Visit __________

Reason for interrupting care: ____________________

If you are accepted for care, who is responsible for your bill? □Self □Spouse □Parent □Workers Comp □Auto Insurance □Medicare □Health Insurance □Personal Injury □Other __________

Are you pregnant? □ Yes □ No □ NA

List your chief complaint(s) (reasons for consulting our office) in order of severity:

1.____________________ For how long? __________

2.____________________ For how long? __________

How would you describe your pain? □Sharp □Soreness □Throbbing □Tingling □Dull □Stiffness □Spasm □Burning □Ache □Weakness □Numbness □Shooting

How would you rate the intensity of your pain? No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable

How often is the pain present? □Constant (81-100%) □Frequent (51-80%) □Occasional (26-50%) □Intermittent (25% or less)

Since your problem began, is your pain □getting worse □staying the same □getting better

How did your problem begin? □Auto accident □Work related □Other type of accident □Gradual Onset □Sudden Onset □No Specific reason Explain: ____________________

Indicate any function(s) that aggravated or are aggravated by your condition(s): check all that apply

□Nothing □Walking □Standing □Sitting □Step Climbing □Driving □Working □Moving/Exercise □Bowel Movements □Digestion □Vision □Breathing □Sinuses □Hearing □Smelling □Lying Down □Inactivity □Sleeping □Menstrual

Does your problem affect your ability to work or affect your routine daily activities? □No effect □Limited restrictions but can function □Needs some assistance with daily activities □Cannot work □Cannot functions without assistance □Totally disabled

List any surgery: ____________________

Do you floss your teeth? □Always □Sometimes □Never

Do you wear Orthodics? □Yes □No

Do you: Belong to a health club? □Yes □No

Take vitamins or supplements? □Yes □No

Drink bottled water? □Yes □No

Your Adult Health Profile **Name: ____________________ HEIGHT: ___________** WEIGHT**: ___________**

CHECK OFF ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAVE HAD IN THE PAST:

Musculo-Skeletal
- ☐Neck Pain
- ☐Arm Pain
- ☐Shoulder Pain
- ☐Hand/Wrist Pain
- ☐Mid Back Pain
- ☐Low Back Pain
- ☐Upper Leg/Hip Pain
- ☐Lower Leg/Hip Pain
- ☐Ankle/Foot Pain
- ☐Walking Problems
- ☐Joint Pain/Stiffness/Swelling
- ☐Arthritis
- ☐Jaw Pain/TMJ

Nervous System
- ☐Nervous
- ☐Numbness
- ☐Paralysis
- ☐Dizziness
- ☐Forgetfulness
- ☐Confusion/Depression
- ☐Fainting
- ☐Convulsions
- ☐Cold/Tingling limbs
- ☐Stress

General Code
- ☐Fatigue
- ☐Allergies
- ☐Loss of Sleep
- ☐Fever
- ☐Headaches
- ☐Diabetes
- ☐Cancer
- ☐Skin Conditions

Gastro-Intestinal
- ☐Poor/Excessive Appetite
- ☐Excess Thirst
- ☐Frequent Nausea
- ☐Vomiting
- ☐Diarrhea
- ☐Hemorrhoids
- ☐Liver Problems
- ☐Gall Bladder Problems
- ☐Weight Trouble (Loss/Gain)
- ☐Abdominal Cramps
- ☐Gas/Bloating after meals
- ☐Heartburn
- ☐Colitis
- ☐Digestive Problems

Genito-Urinary
- ☐Bladder/Kidney Trouble
- ☐Painful/Excessive Urination
- ☐Discolored Urine

C-V-R
- ☐Chest Pain
- ☐Short Breath
- ☐Blood Pressure Problem
- ☐Irregular Heartbeat
- ☐Heart Disease
- ☐Lung Congestion
- ☐Respiratory Condition
- ☐Varicose Veins
- ☐Ankle Swelling
- ☐Stroke

EENT
- ☐Vision Problems
- ☐Dental Problems
- ☐Sore Throat
- ☐Earaches
- ☐Stuffed Nose

Females Only: When was your last period? __________ ☐Menstrual Irregularity ☐Menstrual Cramps ☐Vaginal Pain/Infection ☐Breast Pain/Lumps

Your Childhood Health Profile

Current research has shown that many of the health problems that occur in our adult life have their beginnings during our childhood years, some starting as early as birth.

Did you have any serious falls as a child? ☐Yes ☐No ☐Unsure

Were you involved in any car accidents as a child? ☐Yes ☐No ☐Unsure

Were you active in youth sports? ☐Yes ☐No ☐Unsure

Did you wear braces? ☐Yes ☐No ☐Unsure

Were you vaccinated? ☐Yes ☐No ☐Unsure

As a child, did you receive regular chiropractic care? ☐Yes ☐No ☐Unsure

Did you have any surgery as a child? ☐Yes ☐No ☐Unsure

Did you use any medications (antibiotics, inhalers, aspirin, etc.) on an on-going basis? ☐Yes ☐No ☐Unsure

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES/CONDITIONS YOU HAD AS A CHILD:

☐Pneumonia ☐Measles ☐Polio ☐Chicken Pox ☐Epilepsy ☐Juvenile Diabetes
☐Mumps ☐Rheumatic Fever ☐Smallpox ☐Pediatric Heart Disease ☐Whooping Cough ☐ADD/ADHD

FAMILY HISTORY: The following members have the same or similar problems as I do:

Condition	Condition	Condition
☐Mother____________________	☐Sister________________________	☐Brother__________________________
☐Father_____________________	☐Spouse_______________________	☐Child____________________________

Patient Signature____ Date _____________

DOCTOR'S NOTES:

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Dr. Parks welcomes you to
Parks Chiropractic Health Center

Our practice of Chiropractic is based on the location and adjustment of Vertebral Subluxations. These spinal subluxations (misalignments) are caused by any stress your body can not properly receive, adapt to, or recover from. These stresses may be PHYSICAL, CHEMICAL OR EMOTIONAL in nature.

As a comprehensive chiropractic office, we are trained to focus on your inborn ability to be healthy. Our first goal is to address the reason that brought you to our office initially. Then we'll offer you the opportunity to learn how to further improve your level of health, wellness and performance into the future. As you know, on a daily basis we experience physical, chemical and emotional stresses that often accumulate and can result in spinal subluxations and a serious loss of one's health and well being. Often times the effects of these subluxations are gradual in nature and can go undetected until they become severe. Symptoms are usually the last signs to appear when something is wrong.

ABOUT YOUR CARE

Patients come to our office for a variety of reasons. Some come for **Initial Intensive/Crisis Care**, which is symptomatic pain relief (patch up care). It corrects the most recent layer of spinal or neurological damage. Others are interested in **Reconstructive/Corrective Care**, which is having the cause of their problem corrected as well as their symptoms relieved (fix up care). It's concerned with correcting the years of damage that occurred when there were few symptoms. And finally, there are those patients that desire **Wellness/Maintenance Care**, which gives them the relief and spinal correction they want in addition to looking forward to maintaining a heightened state of wellness and vitality, enhancing the quality of their life and their family's life now and into the future.

Please choose the type of care that best fits your health and life style goals:

☐Relief care ☐Corrective care ☐Comprehensive wellness care

☐Check here if you want the doctor to select the appropriate care for your condition

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. Parks and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

If your care requires X-Rays to be taken, the fee paid for this service is for analysis only. The films themselves are theproperty of the Parks Chiropractic Health Center.

All first visit charges are payable when services are rendered unless prior arrangements have been made.

I understand and agree that health and accident insurance politics are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHANRGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature______________________________ Date__/__/__ Witness________________