Name: _____

Family History

	RELATIONSHIP	DESCRIBE
Cancers		
Heart disease		
Diabetes		
Spinal disorders		
Other		

Please check the appropriate boxes for any symptoms which you currently have.

GENERAL
- ☐ Allergies
- ☐ Bruise Easily
- ☐ Chronic Cough
- ☐ Dizziness/Fainting
- ☐ Depression
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Itching / Rash
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Tremors

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Bursitis
- ☐ Poor Posture
- ☐ Spinal curvature

PAIN or NUMBNESS in:
- ☐ Low Back
- ☐ Hip or Knee
- ☐ Leg or Foot
- ☐ Neck
- ☐ Shoulder or Elbow
- ☐ Arm or Hand

GASTRO-INTESTINAL
- ☐ Abdominal pain
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids
- ☐ Intestinal Parasites
- ☐ Liver Trouble / Jaundice
- ☐ Nausea
- ☐ Vomiting

EYES/EARS/ NOSE
- ☐ Asthma
- ☐ Colds
- ☐ Ear aches
- ☐ Ear Noises
- ☐ Eye Pain
- ☐ Failing Vision
- ☐ Gum disease
- ☐ Nose Bleeds
- ☐ Thyroid Problems
- ☐ Sinus Infection
- ☐ Spit / Cough Blood
- ☐ Sore Throat

CARDIO-VASCULAR
- ☐ Chest Pain
- ☐ Difficult Breathing
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles/Legs
- ☐ Varicose Veins

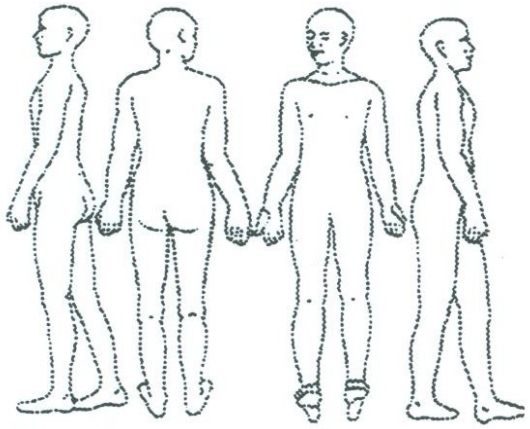
GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Uncontrolled Urination
- ☐ Kidney Infection / Stones
- ☐ Painful Urination
- ☐ Prostate Problems
- ☐ Hernia

FOR WOMEN ONLY
- ☐ Breast Pain / Tenderness
- ☐ Menstrual Cramps / Pain
- ☐ Excessive Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Menstrual Low Back Pain
- ☐ Vaginal Discharge

ARE YOU PREGNANT?

☐ Yes ☐ No

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

CHECK THE FOLLOWING CONDITIONS YOU HAVE / HAD:

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Miscarriages
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name:_____ Phone:_____ Relationship:_____

Confidential Patient Case History

Name:_____ Date:_____

CURRENT CONDITION

Please describe the **primary** problem / reason for this visit _____

_____

_____

_____

How and when did symptoms first occur?_____

_____

_____

Is the condition progressively worsening? Yes____ No____ Symptoms: Are constant____ Come and go____

What aggravates your condition? _____

What helps / alleviates your condition?_____

Does this condition interfere with: Work___ Sleep___ Daily Routine___ How? _____

Have you had this or similar conditions in the past?_____

Have you had previous chiropractic care?_____ If yes, Name of doctor _____

Response to treatments _____ Date of last care: _____

List any other doctors seen for these problems_____

List previous diagnosis or treatments you have received for present condition: _____

_____

_____

List any **secondary / other** complaints: _____

_____

Details about above complaints: _____

_____

_____

ADDITIONAL HISTORY

List surgical operations and years:_____

_____

_____

_____

Have you ever been in an auto accident: Yes / No _____ Approximately how long ago? _____

Describe _____

List any fractures, trauma, concussion, or hospitalizations you have suffered: _____

_____

Have you ever had mental or emotional disorders? Yes /No___ Describe_____

List medications (both over-the-counter & prescriptions). Please indicate name, dosage and duration of use):
Include NSAIDs, analgesics, muscle relaxants, antidepressant/anxiety, sedatives, hormones, birth control pills, anti-hypertensives, antibiotics/virals/fungals, allergy/sinus medications, ulcer medications...

_____

_____

List any medications you are allergic to_____

When was the last time you really felt good? _____

List any vitamins or herbs take _____

_____

Patient Information Sheet

Name_____ Date_____
Address_____ City_____ State____ Zip Code_____
Home Phone( )_____ Cell Phone ( )_____
Employer Name _____ Work Phone ( )_____
Fax #_____ E-mail_____ Emergency Contact_____
Social Security Number_____-____-_____ Date of Birth_____ Age_____
Male / Female Marital Status _____ Spouse _____
Who referred you to this office?_____

INSURANCE INFORMATION

Insured's Name (if different than patient)_____
Insured's Address (if same as patients put same)_____
City_____ State _____ Zip Code _____ Phone_____
Insured's Date of Birth_____
Relationship to Patient: same spouse parent other_____

Is this case related to current or previous employment? Y__ N__
Is the condition related to an auto accident? Y__ N__
Is the condition related to another type of accident? Y___N___
Is there another health benefit plan? Y___N___

Release of Information

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long term authorization card.
Signed_____Date_____

Assignment of Benefits

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I the undersigned patient irrevocably sign and transfer assignment of benefits to Chung & Waggoner Health Center, Inc. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe and agree to pay in a current manner.
Signed_____Date_____