CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Is the purpose of this appointment related to a car accident or a work related accident? If yes, please notify the receptionist for a different set of paperwork.

Today's Date_____

PATIENT INFORMATION

Name: (First, M, Last)_____**Preferred Name**: _____

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

Home:_____**Mobile**:_____**Work**:_____

Email:_____**Gender**: M / F_____ **Marital Status**: S / M / D / W/ Other

Best way to reach you: home / cell / work / email **Social Security #** _____ **Date of Birth**_____

Occupation: _____Employer: _____

Who may we thank for referring you to our office? _____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: _____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander/ Other / Decline to Answer

Height _____**Weight**_____ **Smoking Status**: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name:_____

Home:_____**Mobile**:_____

Relationship: Child / Parent / Spouse / Other:_____

Name of Previous Chiropractor:_____

Date of Last Chiropractic Adjustment:_____

Primary Care Physician:_____
Doctor's Phone:_____

FINANCIAL INFORMATION -- *Please allow our staff to photocopy your ID and Insurance cards*

Insurance ***Self Pay (Cash)*** ***Personal Injury/Auto*** ***Other (please explain)***

MEDICATIONS:

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) ***Did you bring a list? Can we make a copy?***

_____

_____

_____

Allergies to Medications: (List and reactions)

_____

_____

_____

Vitamins & Supplements: (List all and frequency)

_____

_____

_____

Review of Systems

Please put a check mark beside the signs and/or symptoms related to the following body systems you now or have had in the **past 30 DAYS**.

CONSTITUTIONAL
- □ Deny All
- □ Chills
- □ Drowsiness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Weakness
- □ Weight Gain
- □ Weight Loss

EYES
- □ Deny All
- □ Blindness
- □ Blurred Vision
- □ Cataracts
- □ Change in Vision
- □ Double Vision
- □ Dry Eyes
- □ Eye Pain
- □ Field Cuts
- □ Glaucoma
- □ Sensitivity to Light
- □ Tearing
- □ Wears Glasses

CARDIOVASCULAR
- □ Deny All
- □ Angina
- □ Chest Pain
- □ Claudication
- □ Heart Murmur
- □ Heart Problems
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Orthopnea
- □ Palpitations
- □ Shortness of Breath
- □ Swelling of Legs
- □ Varicose Veins

RESPIRATORY
- □ Deny All
- □ Asthma
- □ Bronchitis
- □ Dry Cough
- □ Productive Cough
- □ Coughing up Blood
- □ Difficulty Breathing
- □ Difficulty Sleeping
- □ Hemoptysis
- □ Pneumonia
- □ Sputum Production
- □ Wheezing

MUSCULOSKELETAL
- □ Deny All
- □ Arthritis
- □ Neck Pain
- □ Decreased Motion
- □ Gout
- □ Injuries
- □ Joint Pain
- □ Joint Stiffness
- □ Locking Joints
- □ Back Pain
- □ Muscle Cramps
- □ Muscle Pain
- □ Muscle Twitching
- □ Muscle Weakness
- □ Swelling

INTEGUMENTARY
- □ Deny All
- □ Breast Lumps / Pain
- □ Change in Nail Texture
- □ Change in Skin Color
- □ Eczema
- □ Hair Growth
- □ Hair Loss
- □ History of Skin Disorders
- □ Hives
- □ Itching
- □ Paresthesia
- □ Rash
- □ Skin Lesions

GASTROINTESTINAL
- □ Deny All
- □ Abdominal Pain
- □ Belching
- □ Black, Tarry Stools
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ Hemorrhoids
- □ Indigestion
- □ Jaundice
- □ Nausea
- □ Rectal Bleeding
- □ Abnormal Stool Caliber
- □ Abnormal Stool Color
- □ Abnormal Stool Consistency
- □ Vomiting
- □ Vomiting Blood

GENITOURINARY
- □ Deny All
- □ Birth Control Therapy
- □ Burning Urination
- □ Cramps
- □ Erectile Dysfunction
- □ Frequent Urination
- □ Hesitancy / Dribbling
- □ Hormone Therapy
- □ Irregular Menstruation
- □ Lack of Bladder Control
- □ Prostate Problems
- □ Urine Retention
- □ Vaginal Bleeding
- □ Vaginal Discharge

ENMT
- □ Deny All
- □ Bad Breath
- □ Dentures
- □ Deviated Septum
- □ Difficulty Swallowing
- □ Discharge
- □ Dry Mouth
- □ Ear Drainage
- □ Ear Pain
- □ Frequent Sore Throats
- □ Head Injury
- □ Hearing Loss
- □ Hoarseness
- □ Loss of Smell
- □ Loss of Taste
- □ Nasal Congestion
- □ Nose Bleeds
- □ Post-Nasal Drip
- □ Sinus Infections
- □ Runny Nose
- □ Snoring
- □ Sore Throat
- □ Ringing in Ears
- □ TMJ Problems
- □ Ulcers

NEUROLOGICAL
- □ Deny All
- □ Change in Concentration
- □ Change in Memory
- □ Dizziness
- □ Headache
- □ Imbalance
- □ Loss of Consciousness
- □ Loss of Memory
- □ Numbness
- □ Seizures
- □ Sleep Disturbance
- □ Slurred Speech
- □ Stress
- □ Strokes
- □ Tremors

PSYCHIATRIC
- □ Deny All
- □ Agitation
- □ Anxiety
- □ Appetite Changes
- □ Behavioral Changes
- □ Bipolar Disorder
- □ Confusion
- □ Convulsions
- □ Depression
- □ Homicidal Indication
- □ Insomnia
- □ Location Disorientation
- □ Memory Loss
- □ Substance Abuse
- □ Suicidal Indication
- □ Time Disorientation

ENDOCRINE
- □ Deny All
- □ Cold Intolerance
- □ Diabetes
- □ Excessive Appetite
- □ Excessive Hunger
- □ Excessive Thirst
- □ Goiter
- □ Hair Loss
- □ Heat Intolerance
- □ Unusual Hair Growth
- □ Voice Changes

HEMATOLOGIC / LYMPHATIC
- □ Deny All
- □ Anemia
- □ Bleeding
- □ Blood Clotting
- □ Blood Transfusions
- □ Bruise Easily
- □ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- □ Deny All
- □ History of Anaphylaxis
- □ Itchy Eyes
- □ Sneezing
- □ Specific Food Intolerance

CURRENT CONDITION INFORMATION **PLEASE ANSWER ALL QUESTIONS**

Describe Major Complaint for seeking care today:_____
Onset of Symptoms:_____Describe how it began:_____

Grade Intensity/Severity of Complaint:None (O) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6)
Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb/ Other:_____

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe)_____

Head - Base of Skull / Forehead / Sides-Temple R / L/ Both Leq - Hip / Thigh-Knee / Foot-Toes R / L/ Both
Arm - Across Shoulder / Elbow / Hand-Fingers R/ L/ Both Other Area:_____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

How does this condition affect your daily activities? (Describe) _____

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other:_____Where?_____
Surgery? (Describe)_____
Medications? OTC / Prescriptions (Describe) _____
Diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____
❑ Acupuncture ❑ Massage ❑ Other:_____

Describe any Secondary Complaints: _____

FAMILY HISTORY:

HEALTH HISTORY (*PLEASE USE REVERSE SIDE OF PAGE IF NEEDED*)

Heart Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Stroke Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Cancer Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Type of Cancer: _____
Hypertension Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Lung Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Alzheimer's Dis Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Diabetes Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Gout Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Scoliosis Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Rheumatoid Arth Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Osteoarthritis Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Low Back Pain Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Tuberculosis Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Multiple Sclerosis Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Migraine Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Disc Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Osteoporosis Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather
Epilepsy Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Any other family history that might be relevant: _____

_____

_____

PAST HEALTH HISTORY: (List even if it was 20 years ago….)

Surgeries – Date, Type and Reason:_____

_____
_____
_____
_____
_____
_____

Major Injuries/Traumas:*(List even if it was 20 years ago or more)*

_____
_____
_____
_____

Major Hospitalizations including year:

_____
_____
_____
_____
_____

Is there anything else you would like the doctor to know?

_____
_____
_____
_____

SOCIAL AND OCCUPATIONAL HISTORY:

Level of Education Complete:
High School / Some College / College Grad
Post Grad / Other

Lifestyle: *(Hobbies, Rec Activities, Exercise, Diet)*

_____
_____
_____
_____

Habits:

Cigarettes – (#/day) _____
Alcohol – (amount/day) _____
Coffee/Tea – (cups/day) _____
Rec. Drugs: (list)_____

Women Only

Are you pregnant?

❑ Yes-Due Date_____
❑ No-Last Menstrual Period_____
❑ Infertility
❑ Painful or Irregular Periods
❑ Vaginal Discharge

Pregnancies with Outcome & Date

_____
_____
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date _____

Office Staff Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Consents

Consent to Bill/Collect Insurance: **I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc), to allow Evans Chiropractic (Dr. Robbie Evans) to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the office or doctor.**

Consent to Examination and Treatment: **I give the doctors and staff of Evans Chiropractic permission to perform all examinations, x-rays, and treatment deemed necessary to MYSELF or MY_____(son/daughter), (child's name) _____ by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.**

Consent to Retrieve Medical Records: **I give the doctors and staff of Evans Chiropractic permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.**

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HIPPA: **A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states that we will not give any information about you except as consented above. The only people we give information to are your parents/guardians if you are a minor or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one).**

_____ _____

Name **Patient/Guardian Signature** **Date**

Women Only

Pregnancy Waiver: **By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time**

_____ _____

Name **Patient/Guardian Signature** **Date**