Heritage Chiropractic Clinic

895 E Walnut Raymore MO 64083 ♦ (816) 322-1990 ♦ FAX (816) 322-0005

PATIENT INFORMATION – PLEASE PRINT – LEAVE NO BLANKS

Today's Date: ____________________ Social Security # : ________________________________

Full Name: ____ Date of Birth__________________

Address: ______________________________________ City/ State: ____________________

Zip: ______________ Cell Phone: ________________ Work/Home/other: __________________

Email: ____

Emergency Contact Name: ________________________ Phone Number: __________________

Emergency Contact Address: ______________________________ Relationship: __________

Marital Status: Married Single Divorced Widowed Other: ______________________

Employment Status: Full-Time Part-Time Retired Not Employed

Student Status: Full-Time Part-Time **Gender:** Male Female

How did you hear about us? Family/Friend – Building Signage – Newspaper – Insurance Company – Office Website – Google – Other: ____

If someone referred you, may we ask who? ____

It is our practice to send a Free Coupon to our current patients who refer others to us. If applicable, may we mention your name on the Coupon? Yes / No

Nature of Today's Problem,/where are you experiencing pain? ____________________________

____

Are the symptoms related to a: Fall – Auto Accident

Brief Description of this Event, (Accident/ Injury, if any): ___________________________

____

Has This Ever Occurred Before? Describe: ______________________________________

Has the symptoms worsened recently: ____

Have you tried to improve symptoms at home? If so, what has helped? ____________________

____

Does any activity worsen symptoms? ____

Are the symptoms disturbing your sleep or any other activities you do on a daily basis? __________

____

Rate the pain on a scale of 1-10 currently with 10 being the worst pain you ever: ________

What is your normal diet like, what type of food are you eating regularly? __________________

Do you exercise? If so, how much and how often? ___________________________________

What are you normal job duties? (i.e. sitting, standing, lifting) ___________________________

How much sleep do you get per night? __________

For Women: When was your most recent women's wellness exam? ____________

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PATIENT HISTORY CHECKLIST

PATIENT'S NAME: ______________________ DOB: __________ DATE: __________

Have you ever been in an Auto Accident? Yes____ No ____
If so, when? (List date or dates) ____

DO YOU HAVE:

1.	Pain that wakes you from a sound sleep?	Yes____	No ____
2.	Headaches for hours or days?	Yes____	No ____
3.	Pain in your neck, jaw or face?	Yes____	No ____
4.	Blurred vision, double vision, or any visual disturbances?	Yes____	No ____
5.	A drooping eyelid or any change in your pupils?	Yes____	No ____
6.	Blackouts or fainting spells, or have you lost consciousness lately?	Yes____	No ____
7.	Any nausea or vomiting?	Yes____	No ____
8.	Vertigo (dizziness)?	Yes____	No ____
9.	Slurred speech?	Yes____	No ____
10.	Ringing in your ears (tinnitus)?	Yes____	No ____
11.	Chest pain?	Yes____	No ____
12.	Any change in bowel or bladder habits or loss of control?	Yes____	No ____
13.	Any unusual bleeding or discharge?	Yes____	No ____
14.	Any coughing up blood or blood in your stools or urine?	Yes____	No ____
15.	A sore that will not heal?	Yes____	No ____
16.	Unexplained weight loss?	Yes____	No ____
17.	Any thickening in your breasts or elsewhere?	Yes____	No ____
18.	A change in any wart or mole?	Yes____	No ____
19.	Indigestion or difficulty swallowing?	Yes____	No ____
20.	A nagging cough or hoarseness?	Yes____	No ____
21.	Night sweats?	Yes____	No ____
22.	A history of stroke in your family?	Yes____	No ____
23.	Cancer now, or ever before?	Yes____	No ____

Do you take Birth Control (pills, patch, etc)? Yes____ No ____
When was your LMP? ____________ Are you pregnant? Yes____ No ____
How many children do you have? ________

Are you seeing any other doctor now for any reason? Yes____ No ____
Why? ____

What prescription medication are you taking if any?
( ) High Blood Pressure Medications: ______________________________
( ) Blood Thinners: ______________________________
( ) Other: ______________________________
What over-the-counter drugs are you taking if any? (Aspirin, etc.): ______________________

Dr. Signature: ______________________

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PATIENT HISTORY CHECKLIST (Page 2)

Patient Name: ______________________________

Who is your Primary Care Physician? ______________________________
PCP Address: ______________________________ Phone: ____________
Other current Doctors (name/ address/ phone): ______________________________
____
May we contact? ____________ Date of most recent physical: ______________________________

MEDICAL HISTORY

(Please list all conditions and previous hospitalizations, surgeries, auto accidents, fractures, strain/sprains, etc.): ______________________________
____
____
____

List Allergies: ______________________________

Have you ever visited a Doctor of Chiropractic before? ______________________________
When and how often? ______________________________

SOCIAL HISTORY

Smoker: Yes____ No ____, If yes, how many packs per day? ______________________________
Alcohol: Yes____ No ____, If yes, how much how frequently? ______________________________

FAMILY HISTORY

Did your mother or father or grandparents have any of the following? Put **M** for mother, **F** for father, **GM** for grandmother, **GF** for grandfather.

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizures/Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes Type I/Type II
( ) Kidney Disease
( ) Pacemaker
( ) Ulcer/Stomach Problems
( ) Stroke
( ) Arthritis/Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Issues
( ) Cancer
( ) Osteoporosis

Comments: ______________________________
____
____
____

Dr. Signature: ______________________________