

## **ABOUT THE PATIENT**

Longie Chiropractic 910 Thompson Blvd. Sedalia, MO 65301 660-829-2600

Name		Today's Date	Birthdate	Age
Address		City	State _	Zip
	Cell Phone			
Significant Other's Na	ame	Kid's Names and Ages	<u>". –                                   </u>	
Your Employer		Type of Work		<u> </u>
e-Mail Address		Have you bee	n to a chiropractor	before? □ No □ Yes
Name of Medical Doo	tor(s)			
	I authorize the doctor or his staff to rel I authorize Longie Chiropractic to rele necessary. I understand I am responsible for all b	ase and / or request records to o		
•	Person responsible for this account if	other than the patient?		
•	For my balance my preferred paymen	t method is: 🗅 Cash 🚨 Check	□ Credit Card	
Patient / Parent Signatur	re (This represents a long term aut	horization for all occasions of service)	Date	

## **REASON FOR SEEKING CARE**

PRESENT COMPLAINTS		
1	How long has this	been an issue?
ls it: □ Dull □ Sharp □ Ache □ Numb / Tingle □ Stabl	oing 🗆 Constant 🗅 Occasio	nal 🗆 Staying the same 🗅 Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning	☐ Worse in evening ☐ Pain	radiates to
2	How long has this	been an issue?
ls it: □ Dull □ Sharp □ Ache □ Numb / Tingle □ Stabt	oing 🗆 Constant 🗅 Occasio	nal ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning	☐ Worse in evening ☐ Pain	radiates to
3	How long has this	been an issue?
ls it: □ Dull □ Sharp □ Ache □ Numb / Tingle □ Stabl		
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning	☐ Worse in evening ☐ Pain	radiates to
4	How long has this	been an issue?
ls it: □ Dull □ Sharp □ Ache □ Numb / Tingle □ Stabb	oing 🗆 Constant 🗆 Occasio	nal 🛚 Staying the same 🖵 Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning	☐ Worse in evening ☐ Pain	radiates to
	8070	
5. Does your condition affect:   Sleep  Work  Daily R	outine 🗆 Sitting 🗀 Driving	Please mark All areas of concern.
6. What makes it better?		
7. What makes it worse?		( ) ( 3 ( ) )
What Doctor's have you seen for this?		
		[[Y´`\] / FR (] \]
	The state of the s	[1/X] $(+1)$
9. Type of treatment:		WIN WIND
10. Results:	Are you pregnant?	11 ( 2 5 ) 11
NOTES:		
	⊒ Yes ⊒ No	

## **GENERAL HEALTH HISTORY**

Allergi Allerg	nes ess of Breath es / Asthma ation Side Effects es or Feet cold e aches e Walking Foot Numbness eg adder Trouble g in Ears oblems ng Problems Problems d Problems Disease / Problems Bothers Eyes		000000000000000000	Urinary Problems Easy Bruising Tobacco Use Dental Problems Fibromyalgia Blood Thinner use HIV Positive Cancer Depression Alcohol UseHigh orLow Blood Pressure Stroke History High Cholesterol TMJ Digestive Problems Pain all Over Tension / Irritability Chest Pains Heart Problems
Migraid Shortn Allergi Medica Diabet Hands	nes ess of Breath es / Asthma ation Side Effects es or Feet cold e aches e Walking Foot Numbness eg adder Trouble g in Ears oblems ng Problems Problems d Problems Disease / Problems Bothers Eyes		000000000000000000	Easy Bruising Tobacco Use Dental Problems Fibromyalgia Blood Thinner use HIV Positive Cancer Depression Alcohol UseHigh orLow Blood Pressure Stroke History High Cholesterol TMJ Digestive Problems Pain all Over Tension / Irritability Chest Pains Heart Pacemaker Heart Problems
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Allergi Allerg	es / Asthma ation Side Effects es or Feet cold a aches e Walking foot Numbness ig ladder Trouble g in Ears oblems ng Problems Problems d Problems Disease / Problems Bothers Eyes		00000000000000	Pental Problems Fibromyalgia Blood Thinner use HIV Positive Cancer Depression Alcohol UseHigh orLow Blood Pressure Stroke History High Cholesterol TMJ Digestive Problems Pain all Over Tension / Irritability Chest Pains Heart Pacemaker Heart Problems
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Trouble Leg / Fainting Gall Bar Ringing Sleeping Vision Liver Early Kidner Call Light Bar Other  List any medicar  Has any Doctor	e Walking Foot Numbness  g adder Trouble g in Ears oblems ng Problems Problems d Problems Disease y Problems Bothers Eyes			Depression Alcohol UseHigh orLow Blood Pressure Stroke History High Cholesterol TMJ Digestive Problems Pain all Over Tension / Irritability Chest Pains Heart Pacemaker Heart Problems
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Thyroid Liver I Liver I Communication Control Communication Control Communication Control Communication Control Communication Control Communication Control Co	d Problems Disease Problems Bothers Eyes tions are you taking:		0 0	Tension / Irritability Chest Pains Heart Pacemaker Heart Problems
Liver I Liver I Liver I Light I Cher Light I List any medica	Disease  / Problems  Bothers Eyes  tions are you taking:	0	0 0 0	Chest Pains Heart Pacemaker Heart Problems
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Light I  Cher  Che	Bothers Eyes		0	Heart Problems
Digital Other  List any medical  Please list all do  Has any Doctor	tions are you taking:		<del>-</del>	
List any medica     Please list all do     Has any Doctor	tions are you taking:			
PAST HIST	or other professional advised you to "Go			No 🗆 Yes, Name
	TORY			
4. List any past au	to collisions:			Was any care received?
				Was any care received?
	ort, recreational, or home injuries			
5 5 60	\$158			
/. Please describe	any past conditions and treatment rece	eivea:		
3. Please list any				
AMILY H				

Mother's side: 

Heart Disease 
Cancer 
Diabetes 
Heavy Medication use 
Arthritis 
Other

is there any other family history you want us to know?\_\_