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

LONGIE CHIROPRACTIC

ABOUT THE PATIENT

Name _____ Today's Date_____ Birthdate _____ Age_____
Address _____ City _____ State _ ___ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Gender ❑ M ❑ F
Significant Other's Name _____ Kid's Names and Ages _____
Your Employer _____ Type of Work _____
e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes
Emergency Contact _____ ph # _____
Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Longie Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- Person responsible for this account if other than the patient?_____
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card

_____ _____
Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

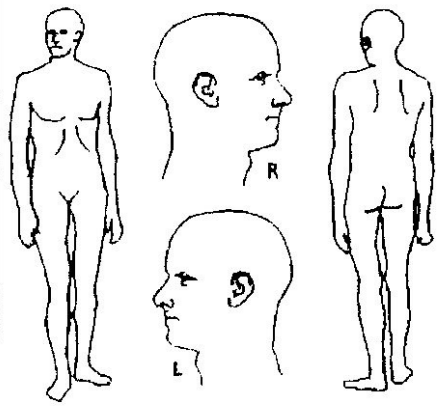
PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ 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? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ 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? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
4. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
_____
6. What makes it better?_____
7. What makes it worse? _____
8. What Doctor's have you seen for this? _____
_____
9. Type of treatment:_____
10. Results: _____
NOTES: _____
_____
_____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications are you taking:**_____

_____

2. **Please list all doctors you are currently seeing:** _____

_____

3. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ **Was any care received?**_____
5. List any past work injuries: _____ **Was any care received?**_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Mother's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Is there any other family history you want us to know?_____