CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: _____

PATIENT INFORMATION

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

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

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

Email: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

Date of Birth:_____ **Occupation:** _____ **Employer:**_____

Referred by *(name)***:** _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:**_____

-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) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Preferred Contact Number**:_____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____**Doctor's Phone**: _____

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

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

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE**:_____

Policy Holder: _____ **Policy Holder**:_____

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

Patient Name: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Major Complaint: _____

When Did This Episode Start (date):_____ **What Event Caused It:** _____

If this is NOT the first time, how long has this been a recurring problem? _____

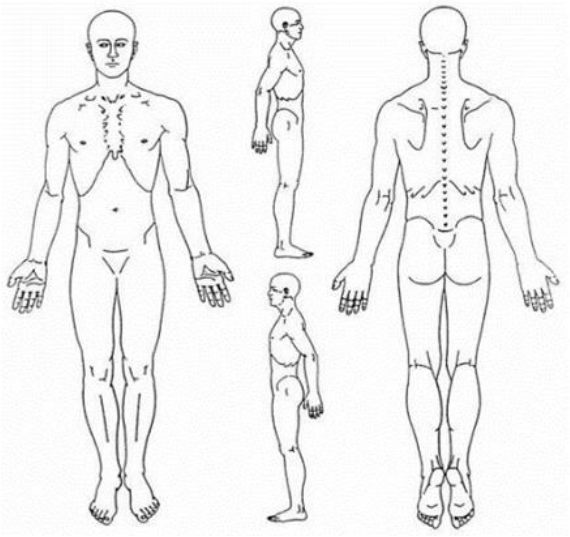
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Tingling / Other:_____

The Complaint is: Constant / Off and On

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **If YES, where:**_____

DRAW AREAS OF COMPLAINTS:



What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What Makes It Worse? Sit / Stand / Walk / Lying / Sleep / Movement

Who Else Have You Seen For This? No One / DC / MD / PT / Massage / ER / Other:_____

- Where: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other:_____ **When and Where:**_____

What Daily Activities are being affected:_____

Patient Name: _____

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐ **NONE**

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____ Type_____ **Other Relevant Family History**:_____

PAST HEALTH HISTORY:

Injuries, Traumas or Hospitalizations: ☐ **NONE** _____

Surgeries – Date, Type and Reason: ☐ **NONE** _____

Current Medications: ***Did you bring a list? Can we make a copy?*** ☐ **NONE** _____

Allergies to Medications: *(List and reactions)* ☐ **NONE**

_____

Vitamins & Supplements: *(List all and frequency)* ☐ **NONE**

_____

Are you ***CURRENTLY*** experiencing any of these symptoms? (Check all that apply)

General:
- ❑ Recent Intentional Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Broken Bones
- ❑ Muscle Spasms/Cramps
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Tobacco Use
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

Genitourinary:
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____

_____

Other Conditions not listed:_____

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

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_____

Doctor Signature _____ Date _____

AUTO ACCIDENT QUESTIONNAIRE

Print Name ***(First MI Last)***_______________________________________ **Date** ____________________

ACCIDENT INFORMATION (Please use back of this page if needed.)

Date & Time of Accident:_______________________ **Number of People in your Vehicle** __________

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger – Behind Driver / Middle / Behind Passenger /

Name of driver *if not you*: ____

Were you wearing a seatbelt? ❑ Yes ❑ No

Make/Model of vehicle you were in:___________________________ **Did airbags inflate?** ❑ Yes ❑ No

Where was your vehicle impacted? ❑ Front ❑ Rear ❑ Driver side ❑ Passenger side

In relation to the base of your skull, where was the headrest? ❑ Above ❑ Below ❑ At the base

During impact you were facing: ❑ Forward ❑ Backward ❑ Right ❑ Left

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No Please Describe:____________________

Were you rendered unconscious ❑ Yes ❑ No If yes, for how long? ____________________________

What was the approx. speed of your vehicle? ______________ **Speed of other vehicle?** ______________

In your own words, please describe the accident in detail:

____

LEGAL INFORMATION

Was a police report filed? ❑ Yes ❑ No

Have you retained an attorney? ❑ Yes ❑ No

If yes, name of attorney _________________________ **Phone** _________________________

Your Auto Insurance Company_________________________ **Claim #** _________________________

Other Auto Insurance Company_________________________ **Claim #** _________________________

MEDICAL INFORMATION

At the Time of the Accident

Did you feel pain immediately after the accident? ❑ Yes ❑ No

If no, when? ❑ Later that Day ❑ Next Day ❑ When? _____________________________________

Did you go to a hospital or see any other doctor? ❑ Yes ❑ No

If yes, when did you go? ❑ Immediately ❑ Next Day ❑ Other

Name of hospital and/or doctor: ____

Were any x-rays taken? ❑ Yes ❑ No

Since the Accident

Are your symptoms: ❑ Getting Better ❑ Staying the Same ❑ Getting Worse

Have you been to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Patient Signature: ____ **Date**: ____________________