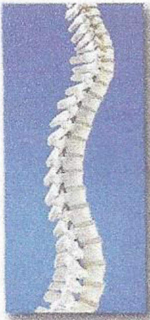

Welcome

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________________ Date ________ SS/HIC/Patient ID#__________
First Middle Initial Last

Address ______________________ City ______________ State _____ Zip _________

Sex: ❑ Female ❑ Male Birthdate ____________ E-mail ______________________

Home Phone (_____)__________ Cell Phone (_____)__________ Work Phone (_____)__________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School ________________________ Occupation ______________

Employer/School Address ______________________ City __________ State ____ Zip ______

Spouse or parent's name ______________ Employer ____________ Work Phone (_____)________

Whom may we thank for referring you to us? ______________________________

Person to contact in case of emergency ____________________ Phone (_____)__________

Responsible Party

Name of person responsible for this account ______________________________

Relationship to patient ______________________ Phone (_____) ______________

Address ______________________ City ____________ State _____ Zip ________

Name of employer ______________________ Work Phone (_____) ______________

Insurance Information

Name of insured ______________________ Relationship to patient ______________

Birthdate ____________ Social Security # ______________ Date employed ___________

Name of employer ______________________ Work Phone (_____) ______________

Address ______________________ City ____________ State _____ Zip ________

Insurance Co. ______________Phone (_____)________ Group #______ Employer # __________

Insurance Co. Address ______________________ City ____________ State _____ Zip ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured ______________________ Relationship to patient ______________

Birthdate ____________ Social Security # ______________ Date employed ___________

Name of employer ______________________ Work Phone (_____) ______________

Address ______________________ City ____________ State _____ Zip ________

Insurance Co. ______________________Group # ______________ Employer # __________

Insurance Co. Address ______________________ City ____________ State _____ Zip ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

CONFIDENTIAL

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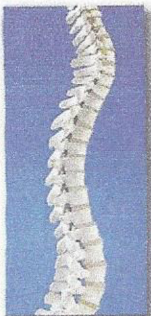


Symptoms

Reason for visit ______________________ When did you first notice the symptoms? __________

Is this condition getting progressively worse? ______________________

Where specifically is the problem(s) located? ______________________

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ______________________

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other ______________

Name and address of other doctor(s) who have treated you for your condition:

____

Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other ________
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	________
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	________

Dates of last exams ______________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any types of surgeries which you have had and the dates which they occurred:

____

Please list all medications you are currently taking: ______________________

Allergies: ______________________

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

____

What vitamins do you currently take? ______________________

What kind of other nutritional supplements do you take (if any)? ______________________

Do you smoke? ❑ No ❑ Yes How much per day? ______________________

How much liquor do you consume on a weekly basis? ______________________

How much coffee or caffeinated beverages do you consume on a daily basis? ______________________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

HEALTH HISTORY FORM

CASE NO FOR OFFICE USE ONLY

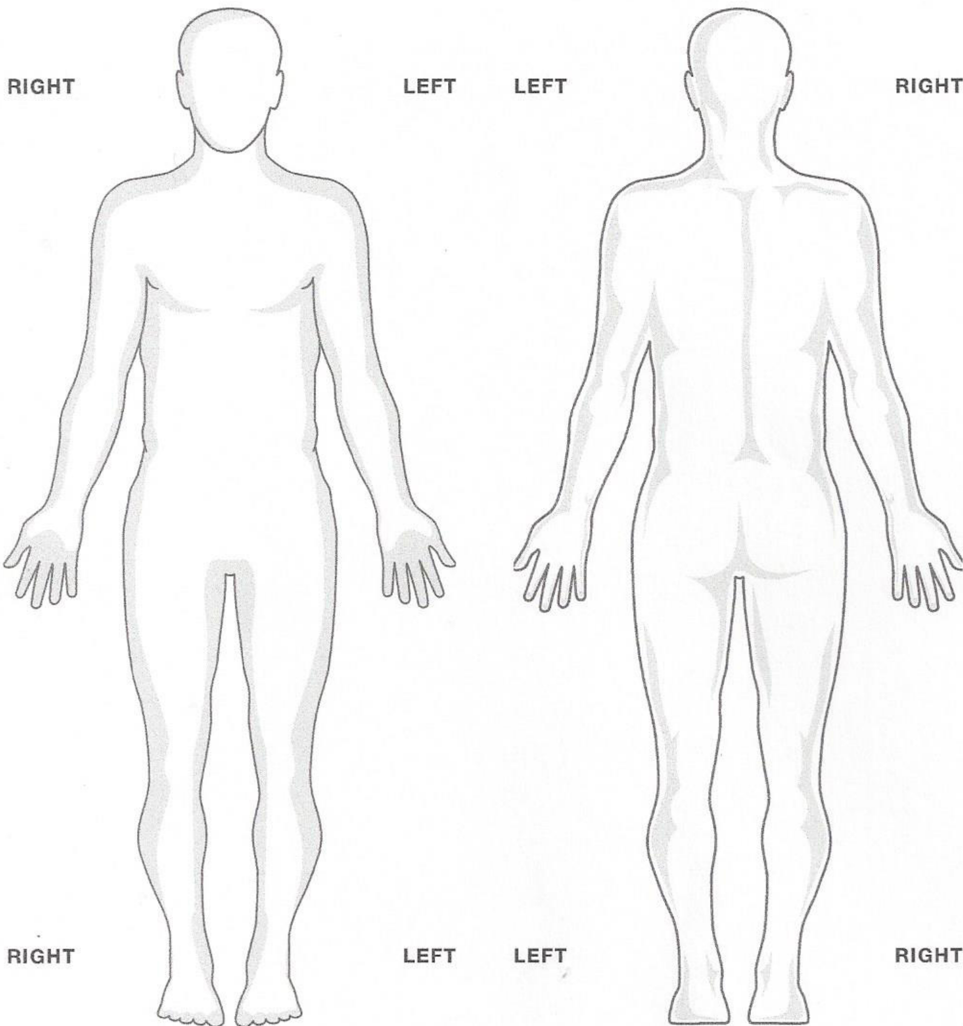
TO INSURE THAT WE HAVE ALL OF YOUR INFORMATION, THIS LAST PAGE SHOWING AREAS OF PAIN MUST BE COMPLETED PRIOR TO YOUR FIRST VISIT. PRINT A COMPLETE COPY OF THIS FORM FOR YOUR RECORDS.

MARK THE AREAS (ON THE BODY DIAGRAM BELOW WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOLS FOR NUMBNESS, PINS AND NEEDLES, BURNING, ACHING, AND STABBING PAIN. MARK AREAS ON DIAGRAM FROM WHERE PAIN RADIATES. INCLUDE ALL AFFECTED AREAS.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
---------------	00000000000	xxxxxxxxxxxxxx	****************	/////////////////
---------------	00000000000	xxxxxxxxxxxxxx	****************	/////////////////
---------------	00000000000	xxxxxxxxxxxxxx	****************	/////////////////

PAIN CHART

PLEASE MARK ON THE PAIN SCALE FROM ZERO TO 10 THE PAIN YOU FEEL WITH THIS CONDITION. 10 BEING THE WORST PAIN YOU HAVE FELT WITH THIS CONDITION.



NECK-SHOULDER-ARM PAIN
ON A SCALE OF ZERO TO 10, I RATE MY DISCOMFORT AS FOLLOWS

1 2 3 4 5 6 7 8 9 10

(0=NO PAIN; 10=SEVERE PAIN)

MID BACK PAIN
ON A SCALE OF ZERO TO 10, I RATE MY DISCOMFORT AS FOLLOWS

1 2 3 4 5 6 7 8 9 10

(0=NO PAIN; 10=SEVERE PAIN)

LOW BACK AND LEG PAIN
ON A SCALE OF ZERO TO 10, I RATE MY DISCOMFORT AS FOLLOWS

1 2 3 4 5 6 7 8 9 10

(0=NO PAIN; 10=SEVERE PAIN)

HEALTH HISTORY FORM

CASE NO [FOR OFFICE USE ONLY]

DO YOU HAVE CHEST PAIN?	YES	NO
DO YOU HAVE CHANGE IN BOWEL OR BLADDER HABITS?	YES	NO
DO YOU HAVE A SORE THAT DOES NOT HEAL?	YES	NO
DO YOU HAVE ANY UNUSUAL BLEEDING OR DISCHARGE?	YES	NO
DO YOU HAVE ANY THICKENING IN YOUR BREASTS OR ELSEWHERE?	YES	NO
DO YOU HAVE INDIGESTION OR DIFFICULTY IN SWALLOWING?	YES	NO
DO YOU HAVE A CHANGE IN ANY WART OR MOLE?	YES	NO
DO YOU HAVE A NAGGING COUGH OR HOARSENESS?	YES	NO
DO YOU HAVE HEADACHES FOR HOURS OR DAYS?	YES	NO
DO YOU HAVE BLURRED VISION?	YES	NO
DO YOU HAVE NIGHT SWEATS?	YES	NO
DO YOU HAVE PAIN IN NECK, JAW, OR FACE?	YES	NO
DO YOU HAVE A DROOPING EYELID OR ANY CHANGE IN YOUR PUPILS?	YES	NO
DO YOU HAVE VERTIGO (DIZZINESS)?	YES	NO
DO YOU HAVE DOUBLE VISION?	YES	NO
DO YOU HAVE ANY OTHER VISUAL DISTURBANCES?	YES	NO
DO YOU HAVE ANY NAUSEA OR VOMITING?	YES	NO
DO YOU HAVE ANY SLURRED SPEECH?	YES	NO
DO YOU HAVE ANY RINGING IN YOUR EARS?	YES	NO
DO YOU PASS OUT EASILY (FAINT)?	YES	NO
DO YOU TAKE BIRTH CONTROL PILLS?	YES	NO
DO YOU HAVE A HISTORY OF STROKE IN YOUR FAMILY?	YES	NO

WHAT PRESCRIPTION MEDICATION ARE YOU TAKING, IF ANY?

HIGH BLOOD PRESSURE MEDICATION

BLOOD THINNERS

OTHER

LIST ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS.

HAVE YOU EVER HAD CANCER?	YES	NO
DOES YOUR PAIN EVER WAKE YOU FROM A SOUND SLEEP?	YES	NO
ARE YOU LOSING WEIGHT NOW WITHOUT TRYING?	YES	NO
ARE YOU COUGHING UP BLOOD OR NOTICING IT IN YOUR STOOLS OR URINE?	YES	NO
HAVE YOU HAD ANY LOSS OF BLADDER OR BOWEL CONTROL?	YES	NO
HAVE YOU LOST CONSCIOUSNESS OR HAD DOUBLE VISION RECENTLY?	YES	NO
ARE YOU SEEING ANY OTHER DOCTOR NOW FOR ANY REASON?	YES	NO
ARE YOU TAKING ANY MEDICATIONS OR OVER-THE COUNTER DRUGS?	YES	NO

IF YES, PLEASE LIST

WHAT WAS THE DATE OF ONSET OF YOUR LAST MENSES?

SOCIAL HISTORY

DO YOU SMOKE?	YES	NO

IF YES, HOW MANY PACKS AND FREQUENCY

DO YOU DRINK ALCOHOL?	YES	NO

IF YES, WHAT DO YOU DRINK? HOW MUCH? AND HOW OFTEN?

FAMILY HISTORY

HAS YOUR MOTHER OR FATHER HAD ANY OF THE FOLLOWING:
PUT AN M = MOTHER, F = FATHER, AND B = BOTH.

HIGH BLOOD PRESSURE	THYROID DISEASE
ULCER/STOMACH PROBLEMS	ASTHMA
HEART ATTACK	CIRCULATION PROBLEMS
STROKE	DIABETES
EMPHYSEMA	CANCER
ARTHRITIS/RHEUMATISM	KIDNEY DISEASE
SEIZURES/CONVULSIONS	OSTEOPOROSIS
MENTAL ILLNESS	PACEMAKER
HIV POSITIVE	

ADDITIONAL COMMENTS

IF YOURS IS AN AUTOMOBILE ACCIDENT INJURY
PLEASE COMPLETE THE FOLLOWING FORM

Date of Accident: ________ Hour: _______ AM PM Location: ______________________________________
What type of Vehicle were you in? ____
If Auto Accident, were you: Driver _______ Passenger ______ Pedestrian ______
Were you seated in the? Front ________ Back ____________ Other _________
Was your vehicle? Stopped ______ Traveling ______ Facing: N, S, E, W
Did the other car strike yours? No, Yes Front, Rear Left Side, Right Side
Did your car strike the other car? No, Yes Front, Rear Left Side, Right Side
Did your car have any damage: No, Yes Where? __________________________
At the time of the collision were you wearing seatbelts? No, Yes
At the time of the collision were you thrown about? No, Yes
Did you strike any body parts? No, Yes What body parts? ______________________________
What part of the Auto did you hit against? ______________________________________
Were there any Cuts, Bruises, Dislocation, Fractures? No, Yes Where? ____________________
Did you notice immediate pain? No, Yes Where? ___________________________________
Were you rendered Unconscious? No, Yes
Did you walk from the car unaided? No, Yes
Where did you go after the accident? ____
How did you get there? ____
If you were seen by another physician, were you examined? No, Yes
What treatment did you receive? ____
Did you stay in confinement? No, Yes Where? _____________________________________
How did you feel the night of the accident? ______________________________________
How did you feel the next day? ___________ Note areas of pain. ___________________________

Previous Doctors you have seen
Dr. ____________________ When _________ What treatment ____________________________
Dr. ____________________ When _________ What treatment ____________________________
Dr. ____________________ When _________ What treatment ____________________________

Have you ever had similar symptoms before this accident? No, Yes Explain
____

AFTER YOUR ACCIDENT, describe your lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort or restricted motion? __ lbs
2. Did you experience this pain, discomfort or restriction before your accident? No, Yes
3. Have your present complaints interfered with any other activities? No, Yes
4. Are you now limited in your lifting ability or body movement that you were previously not?
   No, Yes Please describe ____
5. Have you missed any days of work? No, Yes First day missed _________ Thru _________
6. What are your job duties? ____
____

Insurance Companies Involved:

My auto insurance company: ____
Insurance company of person responsible for injuries: ______________________________________

Have you been contacted by an adjuster or company representing this claims? No, Yes Who?
Name ___________________ Address ________________________ Telephone ________________

Do you have an attorney that has advised you in the case? No, Yes Who?
Name ___________________ Address ________________________ Telephone ________________