PERSONAL HISTORY

Please print carefully. Your report is confidential and treated as such by our staff.

Today's Date _____ File # _____

Name _____ Address _____

City _____ State _____ Zip _____ Birth date _____

Home Phone _____ EMail _____ Age _____ Sex ☐ M ☐ F

SS # _____ Spouse's SS # _____ No. of children & ages _____

Employer _____ Type of Work _____ Work phone _____

Cell # _____ Referred to this office by _____

Marital Status (check one) ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Who is responsible for your bill? **You** and ☐ Spouse ☐ Worker's Comp ☐ Auto Ins. ☐ Medicare ☐ Major Medical

Name and ID# of Insurance Co. _____

CURRENT HEALTH CONDITION

What are your major complaints? List **ALL** symptoms in order of importance: Date problem began:

1 _____ _____

2 _____ _____

3 _____ _____

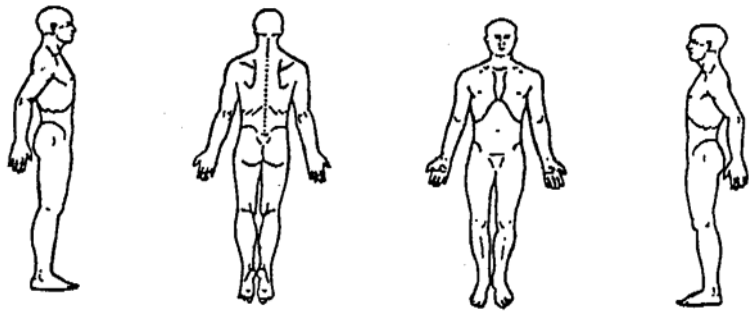
4 _____ _____

5 _____ _____

Please put a mark on the scale to show how bad your usual discomfort has been recently.

No discomfort	0	1	2	3	4	5	6	7	8	9	10	Worst possible discomfort

Please indicate the areas of problem(s) on the appropriate figures below:



How did your injury occur?

☐Motor Vehicle Accident ☐Work Related Accident

☐Other _____

Are you presently disabled as a result of the accident?
☐YES ☐NO

Date last worked _____

Date of Accident _____

Police report? ☐YES ☐NO

Were you the ☐Driver ☐Passenger ☐Bicyclist ☐Pedestrian? (Check one) Seat belt on? YES ☐ NO ☐
Were you taken to the hospital? ☐YES ☐NO By ambulance? ☐YES ☐NO

Owner of vehicle: ☐SELF ☐Other WHO? _____

Location of accident _____

Description of accident _____

_____

Have you notified the insurance company? ☐YES ☐NO
Do you have an attorney for this case? ☐YES ☐NO If YES, name and address:

_____

FOR WORK-RELATED ACCIDENTS:

Have you notified your employer? ☐YES ☐NO Name of supervisor _____

Employer's address _____ Employer's phone _____

Was an accident report completed? ☐YES ☐NO When? _____

Are you pregnant? ☐ Yes ☐ No Date of last period: _____ ☐ check if you have a **PACEMAKER**

Patient's Signature X _____

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE EVER HAD:

- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Anemia
- ☐ Measles
- ☐ HIV positive
- ☐ Mumps
- ☐ Small pox
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Thyroid
- ☐ Allergies
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental disorders
- ☐ Lumbago
- ☐ Eczema
- ☐ Psoriasis

DO YOU USE:

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White sugar
- ☐ Pot
- ☐ Other drugs

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain ☐ Stiffness
- ☐ Walking problems
- ☐ Difficulty chewing or ☐ Clicking jaw
- ☐ General stiffness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion or ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Tingling or ☐ Cold extremities
- ☐ Stress

GASTROINTESTINAL

- ☐ Poor or ☐ Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems
- ☐ Weight trouble
- ☐ Abdominal cramps (not menstrual)
- ☐ Gas or ☐ Bloating after meals
- ☐ Heartburn
- ☐ Black or ☐ Bloody stools
- ☐ Colitis

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headache ☐ Migraines

GENITO-URINARY

- ☐ Bladder trouble
- ☐ Painful or ☐ Excessive urination
- ☐ Discolored urine
- ☐ Prostate or ☐ Sexual dysfunction

CARDIO-VASCULAR

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems or ☐ Congestion
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke

EYES EARS NOSE THROAT

- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Stuffed nose

FEMALE ONLY

- ☐ Menstrual irregularity
- ☐ Menstrual cramps
- ☐ Vaginal pain or ☐ Infection
- ☐ Breast pain or ☐ lumps

Are you pregnant? ☐ Yes ☐ No

Date of last period: _____

MEDICATION YOU NOW TAKE?

- ☐ Birth control pills _____
- ☐ Aspirin/Tylenol _____
- ☐ Ibuprofen _____
- ☐ Pain killers _____
- ☐ Muscle relaxant _____
- ☐ Blood pressure _____
- ☐ Insulin _____
- ☐ Thyroid _____
- ☐ Heart _____
- ☐ Hormones _____
- ☐ Other: _____

MAJOR SURGERY OR OPERATIONS:

- ☐ Tonsils
- ☐ Appendix
- ☐ Gall bladder
- ☐ Hernia
- ☐ Heart
- ☐ Back
- ☐ Neck
- ☐ Hysterectomy
- ☐ Prostate
- ☐ Other:
- ☐ **PACEMAKER**

FAMILY HISTORY

The following members have a same or similar problems as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of natural, non-invasive methods such as spinal adjustments, massage, nutrition or acupuncture. I authorize payment of medical benefits to the undersigned practitioner.

Patient's signature **X** _____ Date _____

Guardian's signature (if patient is a minor) _____