Date: _____ **Pt. #_____**

CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____ **Home Phone: _____**

First MI Last

Address: _____ **Work Phone**: _____

City: _____ **Cell**: _____

State: _____**Zip**: _____ **E-mail Address**: _____

Birth date: _____ **Age**: _____ **Sex**: [ ] **M** [ ] **F** **Height**: _____ **Weight**: _____

Please Check One: [ ] **Single** [ ] **Married** [ ] **Divorced** [ ] **Separated** [ ] **Widowed**

Business/Employer: _____ **Type of Work**: _____

Your SSN#: _____ **Who May We Thank For Referring You? _____ Or**

Did you find us by: [ ] **Phone Book** [ ] **TV** [ ] **Radio** [ ] **Health Talk** [ ] **Screening** [ ] **News Paper** [ ] **Mailer**

Spouse's Name: _____ Birth date: _____ Spouse's SS#: _____

Child's Names: _____Age: _____ Birth date: _____

Child's Names: _____Age: _____ Birth date: _____

Child's Names: _____Age: _____ Birth date: _____

Who is Responsible for Your Bill, You and: [ ] Health Insurance [ ] Medicare [ ] Auto Insurance

Method of Payment for Today's Services: [ ] Cash [ ] Check [ ] Credit Card [ ] Debit Card

CURRENT HEALTH CONDITION

Please List Your Chief Health Complaints, Symptoms, or Concerns in the Order of their Severity Below:

1. _____ Since/How Long: _____

2. _____ Since/How Long: _____

3. _____ Since/How Long: _____

Describe the quality of your pain: Sharp___ Dull Ache___ Burning___ Tingly___ Numb___ Stabbing___

Does your pain radiate into your: Arms___ Hands___ Fingers___ Legs___ Feet___ Toes___

What is the timing of this problem? Constant ___ Intermittent ___ Occasional ___ Cyclic ___

Is Your Condition Due To: [ ] Auto Accident [ ] Work Injury [ ] Gradual Onset [ ] Unknown [ ] Other Accident

Date of Accident or Injury: _____Please Describe: _____

Name_____ **Date:** _____ **Pt. #**_____

Were You Disabled from Work? [ ] Yes [ ] No If yes, Please Give Dates: _____

Date Symptoms Appeared: _____ **Are Your Symptoms: [ ] Better [ ] Getting Worse [ ] About the same**

Is there anything you do that makes this problem better?

_____

Is there anything you do that makes this problem worse?

_____

[ ] Standing [ ] Walking [ ] Sitting [ ] Lying [ ] Bending [ ] Lifting [ ] Twisting [ ] Coughing

Have You Had These Symptoms Before? [ ] Yes [ ] No If yes, when? _____

Have You Been Treated by Anyone Else for This Condition? [ ] Yes [ ] No

If Yes, Name: _____**Date consulted** ____/____/____ **Diagnosis**_____

Were They a/an: [ ] MD [ ] Chiropractor [ ] Acupuncturist [ ] Dentist [ ] Therapist

Have you ever been treated by a Chiropractor? [ ] Yes [ ] No If Yes, When _____

Please List All Medications You Are Taking at This Time and What they Are for: _____

_____

_____

Have You Been Treated For Any Health Condition in the Last Year [ ] Yes [ ] No

If Yes, Please Explain: _____

Major Accidents, Injuries, or Falls You Have Had in Your Lifetime: _____

_____

_____

PAST HEALTH HISTORY

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

PLEASE CHECK ANY OF THE FOLLOWING DISEASES OR CONDITIONS YOU HAVE HAD:

[ ] Pneumonia	[ ] Mental Disorder	[ ] Epilepsy	[ ] Auto Immune Disease	[ ] Eczema
[ ] Rheumatic Fever	[ ] Influenza	[ ] Diabetes	[ ] Heart Disease	[ ] Measles
[ ] Tuberculosis	[ ] Pleurisy	[ ] Cancer	[ ] Thyroid	[ ] Lumbago
[ ] Whooping Cough	[ ] Arthritis	[ ] Anemia	[ ] HIV Positive	[ ] Asthma
[ ] Kidney Stones				

Name_____ **Date**: _____ **Pt. #**_____

PLEASE **CHECK THE BOX** OF SYMPTOMS YOU HAVE HAD IN THE **PAST 6 MONTHS:**
THEN **CIRCLE** THE SYMPTOMS YOU ARE EXPERIENCING AT THE **PRESENT TIME:**

MUSCULO-SKELETAL
[ ] Head Pain / Problems
[ ] Neck Pain / Problems
[ ] Shoulder Pain / Problems
[ ] Arm Pain / Problems
[ ] Hand Pain / Problems
[ ] Mid Back Pain / Problems
[ ] Chest Pain / Problems
[ ] Stomach Pain / Problems
[ ] Low Back Pain / Problems
[ ] Hip Pain / Problems
[ ] Leg Pain / Problems
[ ] Foot Pain / Problems
[ ] Walking Pain / Problems
[ ] Chewing / Jaw Pain / Problems
[ ] General Stiffness

NERVOUS SYSTEM
[ ] Nervousness
[ ] Numbness
[ ] Paralysis
[ ] Dizziness
[ ] Forgetfulness
[ ] Confusion / Depression
[ ] Fainting
[ ] Convulsions
[ ] Cold / Tingling Extremities
[ ] Muscle Cramping
[ ] Stress

GENERAL SYSTEM
[ ] Fatigue
[ ] Allergies
[ ] Fever
[ ] Headaches
[ ] Migraine Headaches
[ ] Tension Headaches
[ ] Sinus Headaches
[ ] Loss of Sleep

SYSTEM GEN1TO-URINARY SYSTEM
[ ] Bladder Trouble
[ ] Painful / Excessive Urination
[ ] Discolored Urine
[ ] Bed-wetting

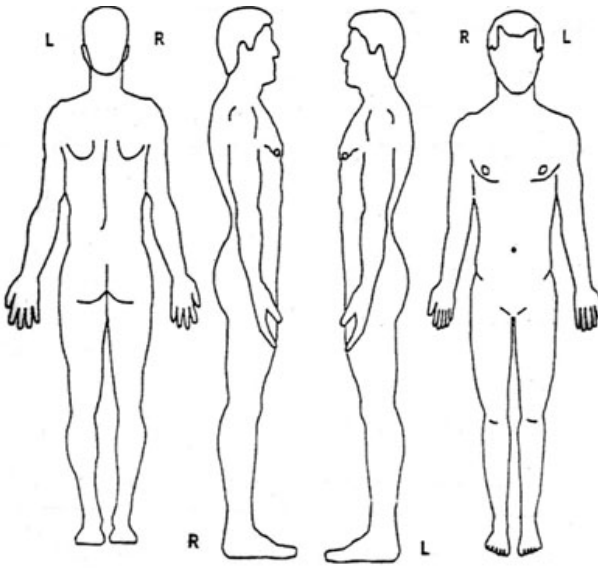
GASTRO-INTESTINAL SYSTEM
[ ] Poor/ Excessive Appetite
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Constipation
[ ] Hemorrhoids
[ ] Liver Problems
[ ] Gallbladder Problems
[ ] Abdominal Cramps
[ ] Gas / Bloating After Meals
[ ] Heartburn / Indigestion
[ ] Black / Bloody Stool
[ ] Colitis
[ ] Weight Trouble

EARS, EYES, NOSE & THROAT
[ ] Sinus Problems
[ ] Vision Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Ear Aches
[ ] Ringing in Ears
[ ] Hearing Difficulty
[ ] Stuffed Nose

MALE/FEMALE
[ ] Menstrual Irregularity
[ ] Menstrual Cramping
[ ] Vaginal Pain / Infections
[ ] Breast Pain / Lumps
[ ] Prostate / Sexual Dysfunction

CARDIO-VASCULAR-RESPIRATORY
[ ] Chest Pain
[ ] Shortness of Breath
[ ] Blood Pressure Problems
[ ] Irregular Heartbeat
[ ] Heart Problems
[ ] Lung Problems / Congestion
[ ] Varicose Veins
[ ] Ankle Swelling
[ ] Stroke

DARKEN THE AREAS OF YOUR PAIN OR SYMPTOMS ON THE DRAWINGS BELOW



PLEASE LIST ALL SURGERIES YOU HAVE HAD AND WHEN: _____

_____

_____

_____

Name_____ **Date:** _____ **Pt. #**_____

DAILY LIFESTYLE & HABITS:	**Please Fill Chart Below Out Completely.**			
Alcohol	**Daily**	**2/ week**	**2/ month**	**None**
Coffee	**>5 cups**	**2-4 cups**	**1 cup**	**None**
Tobacco	**>2 packs**	**1 pack**	**<1/2 pack**	**None**
Drugs	**Daily**	**1 / week**	**1 / month**	**None**
Exercise	**Daily**	**3/week**	**1 / week**	**None**
Sleep	**>10 hrs**	**7-10 hrs**	**4-7 hrs**	**<4 hrs**
Appetite	**Heavy**	**Moderate**	**Light**	**None**

In Case of an Emergency, please give the name of a relative or close friend not living with you

Name: _____ **Home Phone:** _____

First MI Last

Address: _____ **Work Phone**: _____

City: _____ **Cell**: _____

PLEASE READ:

I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that this Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the this Clinic will be credited to my account upon receipt. <u>However,</u> I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment of these services in full. I also understand that if I suspend or terminate my care in this office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by me personally at the full retail price.
I also agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion and it is placed in collections.

Patient's Signature: _____ **Date**: _____

Parent or Guardian's Signature Authorizing Care: _____ **Date**: _____

OUR PURPOSE AT THIS CLINIC IS TO SUPPORT AS MANY FAMILIES AS POSSIBLE IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALING AND HOW THEIR BODIES FUNCTION AND IN TURN GO OUT AND EDUCATE OTHERS.

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem:

_____