Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Middle Name**_____

Last Name _____ **Nick Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Social Security Number _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the question: (Answer must be 6+ characters)_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications: including dosage, times per day taken, quantity of bottle, and form of med (tablet, capsule, liquid.)
If there are no current medications, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List any known allergies you have had to any medications. Include your reaction to the medication.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: (all health issues) _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

❑ Drugs / Medicine ❑ Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy?_____

_____

How was your delivery?

❑ Labor chemically induced ❑ Labor was Dr. assisted
❑ C-section delivery ❑ Forceps/Vacuum extraction?
❑ Did Dr. pull or twist baby? ❑ Premature delivery

Please explain _____

Did you nurse the baby? ❑ Yes ❑ No

Did your baby have colic? ❑ Yes ❑ No?
Feeding problems? ❑ Yes ❑ No
Vaccinations? ❑ Yes ❑ No?

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

❑ Allergies
❑ Asthma
❑ Attention problems
❑ Bed wetting
❑ Breathing problems
❑ Colic
❑ Constipation
❑ Digestive problems
❑ Ear problems
❑ Frequent colds
❑ Headaches
❑ Hyperactivity
❑ Irritability
❑ Skin problems
❑ Sleeping disorders
❑ Tubes in the ears
❑ Vision problems
❑ Other _____

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever: …taken antibiotics?	❑	❑	_____
…been hospitalized?	❑	❑	_____
…had a severe fall?	❑	❑	_____
…been in a car accident?	❑	❑	_____
Is your child …accident prone?	❑	❑	_____
Had Surgery? Please Explain…			_____
…currently taking any medication(s)?	❑	❑	_____
…having difficulty interacting with others?	❑	❑	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished?

GOALS FOR MY CHILD'S CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ **Relief care** – Symptomatic relief of pain or discomfort

❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition.

Parent or guardian's signature:_____ _____ Date:_____

Child's name:_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian:_____ Date:_____

PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____

Birth date _____

SS#_____

Age _____ Gender _____ Weight_____

ABOUT THE PARENT

Name_____

Employer_____

Work address _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

Driver's License # _____

E-mail address_____

Payment method ❑ Cash ❑ Check ❑ Credit card

VACCINATIONS

Have you chosen to vaccinate your child? ❑ Yes ❑ No

If yes, check all that your child has received.

❑ DPT ❑ MMR ❑ Chicken Pox ❑ Hepatitis ❑ Other

Describe any and all reactions to vaccine(s).

_____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to
❑ Sports ❑ Auto ❑ Fall ❑ Home Injury
❑ Other

Please explain _____

When did this condition begin? _____

Has this condition
❑ gotten worse ❑ stayed constant ❑ comes and goes

Does this condition interfere with
❑ Sleep ❑ Daily routine ❑ Other activities

Please explain _____

Has this condition occurred before? ❑ Yes ❑ No

Please explain _____

Have you seen other doctors for this condition?
❑ Yes ❑ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that	Yes	No
• Doctors of Chiropractic work with the nervous system?	❑	❑
• The nervous system controls all bodily functions and systems?	❑	❑
• Chiropractic is the largest natural healing profession in the world?	❑	❑
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	❑	❑

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name_____

Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No