

# Personal History

Date: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F E-Mail: \_\_\_\_\_

Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Check One:  Married  Single  Widowed  Divorced  Separated  No. of Children \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Who Is Responsible For Your Bill?  Self  Spouse  Worker's Comp.  Medicaid  Medicare  Auto Insurance

Personal Health Insurance  Other: \_\_\_\_\_

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## Current Health Condition

Purpose of this appointment: \_\_\_\_\_

Other Doctors Seen For This Condition: \_\_\_\_\_

When Did This Condition Begin: \_\_\_\_\_

If Disabled From Work, Please Give Dates: \_\_\_\_\_  Job Related  Auto Related

Drugs You Are Taking Now:  Nerve Pills  Pain Killer/Muscle Relaxers  Insulin  Blood Pressure Medicine

Other \_\_\_\_\_

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## Past Health History

Please check or describe: Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia

Broken Bones  Other (Please explain) \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_

Hospitalization (Other Than Above): \_\_\_\_\_

Previous Chiropractic Care:  None

Doctor's Name & Approx. Date of Last Appointment: \_\_\_\_\_

Have you been treated for any health condition in the last year?  Yes  No If yes, please explain:

\_\_\_\_\_

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Malaria        | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Alcoholism         |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Typhoid Fever   | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Measles        | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Mental Disorder    |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Lumbago            |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Small Pox      | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Eczema             |

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

**Musculo-Skeletal Code:**

- Low Back Pain
- Pain between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw

**Nervous System Code**

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

**General Code**

- Allergies
- Loss of Sleep
- Fever
- Headaches

**Gastro-Intestinal Code**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**Genito-Urinary Code**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**C-V-R Code**

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

**EENT Code**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffy Nose

**Male/Female Code**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

**Females Only:**

When was your last period? \_\_\_\_\_

Are you pregnant?  Yes  No  Maybe

**DO NOT WRITE BELOW THIS LINE**

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Diagnosis:

Patient Accepted:  Yes  No

Doctor's Signature \_\_\_\_\_

**Why Chiropractic?** People go to Chiropractors for a variety of reasons. Some go for symptomatic relief or pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Comprehensive Care). 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     Corrective Care     Comprehensive Care     Check here if you want the Doctor to select the type of care appropriate for your condition.

\_\_\_\_\_ Date

\_\_\_\_\_ Patient Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

*The purpose of  
our Chiropractic Clinic  
is to support each individual  
in achieving their Optimum Health  
and to  
Educate them so that they may  
understand Health and Chiropractic  
and in turn, educate others.*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 upon 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse  
Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_