

CONFIDENTIAL PATIENT HISTORY

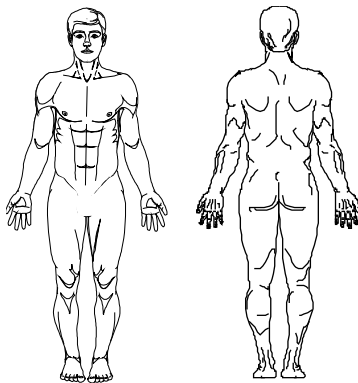
Name _____ Date _____
Address _____ City _____ State _____ ZIP _____
Phone (Home or Cell) _____ Date of Birth _____ Age _____
E-mail address _____ Marital Status S M D W Number of Children _____
Occupation _____ Employer _____ Years there _____
Spouse's Name _____ Occupation _____
How did you hear about our office? _____
Are you covered by **Medicare?** Y N **State Insurance Aid?** Y N **Group Health Insurance?** Y N

What is your major complaint? _____
How long have you had this? _____ Have you had this before? Y N Have you missed work? Y N
What activities aggravate your condition? _____
What treatments have you done in the past for this? _____
How long since you really felt good? _____
How is this having an impact on your life? _____
Any other complaints: _____

List date and type of surgeries or hospitalizations _____
Smoking Status: [] Never Smoker [] Former Smoker [] Current-Sometimes Smoker [] Current-Everyday Smoker
Are you pregnant or might be? Y N Are you currently taking any medication? Y N
What med and for what condition? _____
What non-prescription drugs, vitamins or supplements are you taking? _____

Other doctors seen for this condition _____
Family doctor _____ Practice Name/Location _____ / _____
Have you ever seen a Chiropractor? Y N Who? _____ For what? _____
Date of last visit to a Chiropractor _____ Do you have a pacemaker? Y N
Now or in the past any type of: Cancer? Y N Infection? Y N Stroke? Y N Heart Disease? Y N
Seizures? Y N Spinal Bone Fracture? Y N

Please use the pictures below and mark your problem areas with an X.



All of the above information is true and correct. I clearly understand and agree that all services rendered to 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 for any reason, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____

Date _____

Circle All Current Problems You Have

DIZZINESS	MIGRAINES	MENSTRUAL DISORDERS	NUMBNESS IN LEGS	LUPUS
HEADACHES	ANXIETY	HEART DISORDERS	NUMBNESS IN FEET	FIBROMYALGIA
VERTIGO	THROAT ISSUES	STOMACH DISORDERS	LOW BACK PAIN	CHEST PAIN
EAR INFECTIONS	THYROID PROBLEMS	KIDNEY PROBLEMS	HIP PAIN OR LEG PAIN	ARM PAIN
NAUSEA	ASTHMA	BLADDER PROBLEMS	SHOULDER PAIN	ADD/ADHD
TMJ	ULCERS	IRRITABLE BOWEL/CROHNS	LIVER DISEASE	DIABETES
EPILEPSY	DISC PROBLEM	INFERTILITY	GASTRIC REFLUX	MID BACK PAIN
NECK PAIN	NUMBNESS IN HANDS	CHRONIC FATIGUE	SCOLIOSIS	CHRONIC SINUS ISSUES

OTHER: _____