

MOTOR VEHICLE ACCIDENT HISTORY

PATIENT DATA

TITLE: MR. MRS. MS. MISS (CHECK ONE) DATE:

FIRST NAME: MI: LAST NAME:

ADDRESS:

CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE: WORK PHONE:

PRIMARY EMAIL:

BEST CONTACT METHOD (Check One) HOME PHONE CELL PHONE WORK PHONE

SS NUMBER: SEX: MALE FEMALE DOB: AGE:

EMPLOYMENT STATUS: EMPLOYED SELF EMPLOYED RETIRED FULL TIME STUDENT PART TIME STUDENT UNEMPLOYED OTHER _____

EMPLOYER NAME: OCCUPATION:

ADDRESS: CITY: STATE: ZIP:

MARITAL STATUS: SINGLE MARRIED OTHER

IF MARRIED, PLEASE FILL OUT THE FOLLOWING FOR YOUR SPOUSE:

FIRST NAME: MI: LAST NAME:

PRIMARY PHONE NUMBER: IS YOUR SPOUSE A PATIENT IN THIS CLINIC? YES NO

CHILDREN: YES NO

IF YES, PLEASE LIST THEIR NAME AND AGE:

RACE (Check One):

WHITE CHINESE ASIAN I CHOOSE NOT TO SPECIFY
 BLACK/AFRICAN AMERICAN JAPANESE ASIAN INDIAN
 HISPANIC KOREAN OTHER _____

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 ITALIAN JAPANESE GERMAN
 SPANISH KOREAN CHINESE OTHER _____
 AMERICAN SIGN LANGUAGE RUSSIAN FRENCH I CHOOSE NOT TO SPECIFY

VERIFICATION QUESTION (Choose only one question by circling the question, then give the answer to that question):

WHAT IS THE NAME OF YOUR FAVORITE PET? WHAT IS YOUR FAVORITE MOVIE? WHAT WAS THE MAKE OF YOUR FIRST CAR?
 IN WHAT CITY WERE YOU BORN IN? WHAT IS YOUR MOTHER'S MAIDEN NAME? WHEN IS YOUR ANNIVERSARY?
 WHAT HIGH SCHOOL DID YOU ATTEND? ON WHAT STREET DID YOU GROW UP? WHAT IS YOUR FAVORITE COLOR?

VERIFICATION ANSWER TO THE CHOSEN QUESTION: _____

PRIMARY CARE PHYSICIAN NAME: PRACTICE NAME:

EMERGENCY CONTACT: PHONE: RELATIONSHIP:

HOW DID YOU HEAR ABOUT OUR CLINIC? OR WHO REFERRED YOU?

FAMILY MEMBER FRIEND PHYSICIAN EMPLOYER ATTORNEY SIGN ON BUILDING INTERNET WEB SITE
 HEALTH CLASS BROCHURE OTHER _____

IF YOU SELECTED "FAMILY MEMBER, FRIEND, OR PHYSICIAN" PLEASE ENTER THEIR NAME:

INSURANCE INFORMATION (Important: If you are not the primary insured please fill out the following)

PRIMARY INSURANCE

INSURANCE COMPANY:

INSURED'S NAME: RELATIONSHIP TO INSURED:

INSURED'S SOCIAL SECURITY #: INSURED'S BIRTHDATE:

INSURED'S EMPLOYER NAME:

ADDRESS: CITY: STATE: ZIP:

SECONDARY INSURANCE

INSURANCE COMPANY:

INSURED'S NAME: RELATIONSHIP TO INSURED:

INSURED'S SOCIAL SECURITY #: INSURED'S BIRTHDATE:

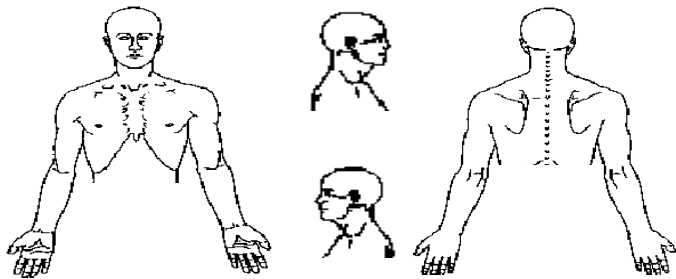
INSURED'S EMPLOYER NAME:

ADDRESS: CITY: STATE: ZIP:

A. Complete the box below and check all boxes that apply OR if this section does not apply to your health history, check here _____ and proceed to next section.

A. NECK / UPPER EXTREMITIES (ARMS/HANDS)

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

- 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE

WHEN DID YOUR SYMPTOMS START?

HOW DID YOUR SYMPTOMS BEGIN?

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- | | |
|---|--|
| <input type="checkbox"/> CONSTANTLY
(76%-100% OF THE DAY) | <input type="checkbox"/> FREQUENTLY
(51%-75% OF THE DAY) |
| <input type="checkbox"/> OCCASIONALLY
(26%-50% OF THE DAY) | <input type="checkbox"/> INTERMITTENTLY
(0%-25% OF THE DAY) |

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- | | | | |
|-----------------------------------|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> DULL | <input type="checkbox"/> SHARP | <input type="checkbox"/> SHARP WITH MOVEMENT | <input type="checkbox"/> THROBBING |
| <input type="checkbox"/> BURNING | <input type="checkbox"/> DEEP | <input type="checkbox"/> ACHING | <input type="checkbox"/> TINGLING |
| <input type="checkbox"/> STABBING | <input type="checkbox"/> CRAMPING | <input type="checkbox"/> PINPRICK | <input type="checkbox"/> NUMBNESS |

DOES YOUR PAIN RADIATE? YES NO
IF YES, WHERE?

ARE YOUR SYMPTOMS:

- | | | |
|--|---|---|
| <input type="checkbox"/> THE SAME ALL THE TIME | <input type="checkbox"/> WORSE: <input type="checkbox"/> A.M. <input type="checkbox"/> MIDDAY <input type="checkbox"/> P.M. <input type="checkbox"/> AT NIGHT | <input type="checkbox"/> AT NIGHT WITH PAIN |
| <input type="checkbox"/> BETTER: <input type="checkbox"/> A.M. <input type="checkbox"/> MIDDAY <input type="checkbox"/> P.M. <input type="checkbox"/> AT NIGHT | <input type="checkbox"/> AT NIGHT WITH PAIN | |

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?

- | | | | |
|---|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING | <input type="checkbox"/> WALKING | <input type="checkbox"/> BENDING |
| <input type="checkbox"/> STAIR STEPPING | <input type="checkbox"/> LIFTING | <input type="checkbox"/> SLEEPING | <input type="checkbox"/> SNEEZING |
| <input type="checkbox"/> LOOKING UP | <input type="checkbox"/> STRAINING | <input type="checkbox"/> REACHING | <input type="checkbox"/> TWISTING |
| <input type="checkbox"/> LOOKING DOWN | <input type="checkbox"/> COUGHING | <input type="checkbox"/> MOVEMENT | <input type="checkbox"/> REST |
| <input type="checkbox"/> LYING SUPINE | <input type="checkbox"/> DRIVING | <input type="checkbox"/> TYPING | <input type="checkbox"/> SCOOPING |
| <input type="checkbox"/> HOUSEHOLD CHORES | <input type="checkbox"/> EXERCISE | <input type="checkbox"/> STOOPING | <input type="checkbox"/> OTHER: _____ |

WHAT RELIEVES YOUR SYMPTOMS?

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING | <input type="checkbox"/> LYING DOWN |
| <input type="checkbox"/> LEANING AGAINST A SUPPORT | <input type="checkbox"/> NO MOVEMENT | <input type="checkbox"/> MOVEMENT |
| <input type="checkbox"/> HEAT IS APPLIED | <input type="checkbox"/> ICE IS APPLIED | <input type="checkbox"/> REST OCCURS |
| <input type="checkbox"/> ADVIL/TYLENOL IS TAKEN | <input type="checkbox"/> R/x MEDICATION | <input type="checkbox"/> ADJUSTMENTS |
| <input type="checkbox"/> TOPICAL PAIN RELIEF GEL | <input type="checkbox"/> STRETCHING | <input type="checkbox"/> EXERCISE |
| <input type="checkbox"/> OTHER: _____ | | |

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? YES NO

IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED OTHER PHYSICIANS FOR YOUR SYMPTOMS? YES NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?

- NONE X-RAYS MRI CT SCAN OTHER: _____

IF YES, WHEN AND WHERE:

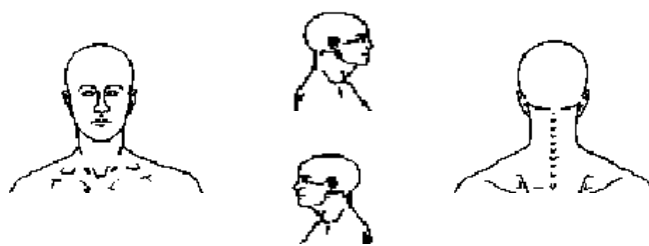
HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO
IF YES, WHEN:

DOCTOR'S NOTES:

B. Complete the box below and check all boxes that apply OR if this section does not apply to your health history, check here _____ and proceed to next section.

B. HEADACHES

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



WHAT IS THE INTENSITY OF YOUR HEADACHES ?

- 0 1 2 3 4 5 6 7 8 9 10
NO PAIN WORST PAIN POSSIBLE

WHEN DID YOUR HEADACHES BEGIN?

ON AVERAGE, HOW OFTEN DO THEY OCCUR?

_____X/WEEK _____X/MONTH _____SPORADIC

WHAT DESCRIBES YOUR HEADACHES?

- | | | | |
|--|---------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> DULL | <input type="checkbox"/> SHARP | <input type="checkbox"/> ACHING | <input type="checkbox"/> DEEP |
| <input type="checkbox"/> STABBING | <input type="checkbox"/> BURNING | <input type="checkbox"/> VICE-LIKE | <input type="checkbox"/> PRESSURE |
| <input type="checkbox"/> THROBBING/PULSATING | <input type="checkbox"/> OTHER: _____ | | |

WHEN DO YOUR HEADACHES USUALLY START?

- | | |
|--|---|
| <input type="checkbox"/> WAKING IN MORNING | <input type="checkbox"/> DURING EVENING |
| <input type="checkbox"/> AT MID-DAY | <input type="checkbox"/> CONSTANT |

WHAT SEEMS TO BRING ON YOUR HEADACHES?

- | | |
|--|---|
| <input type="checkbox"/> PHYSICAL ACTIVITY | <input type="checkbox"/> CAFFEINE |
| <input type="checkbox"/> EXCESSIVE STRESS | <input type="checkbox"/> CERTAIN FOODS |
| <input type="checkbox"/> ALCOHOL | <input type="checkbox"/> MENSTRUAL PERIOD |
| <input type="checkbox"/> SINUS CONGESTION | <input type="checkbox"/> OTHER: _____ |

HOW LONG DO YOUR HEADACHES LAST?

- | | | | |
|--|---------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> < 1 HR | <input type="checkbox"/> 1-3 HRS | <input type="checkbox"/> >3 HRS | <input type="checkbox"/> ALL HRS |
| <input type="checkbox"/> SEVERAL HOURS | <input type="checkbox"/> OTHER: _____ | | |

DO YOUR HEADACHES WAKE YOU? YES NO

DO THE FOLLOWING OCCUR WITH YOUR HEADACHES?

- | | |
|--|--|
| <input type="checkbox"/> NAUSEA/VOMITING | <input type="checkbox"/> LIGHT/SOUND SENSITIVE |
| <input type="checkbox"/> WEAKNESS | <input type="checkbox"/> VISION PROBLEMS |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> TREMOR |
| <input type="checkbox"/> OTHER: _____ | |

WHAT MAKES YOUR HEADACHE BETTER?

- | | |
|---|---|
| <input type="checkbox"/> NOTHING | <input type="checkbox"/> REST |
| <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> ICE/COLD PACKS |
| <input type="checkbox"/> MASSAGE | <input type="checkbox"/> STANDING |
| <input type="checkbox"/> NSAIDS (ASPIRIN, TYLENOL, ADVIL) | <input type="checkbox"/> OTHER: _____ |

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? YES NO
IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED ANY OTHER PHYSICIANS FOR YOUR SYMPTOMS? YES NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?

- NONE X-RAYS MRI CT SCAN OTHER: _____

IF YES, WHEN AND WHERE:

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO
IF YES, WHEN:

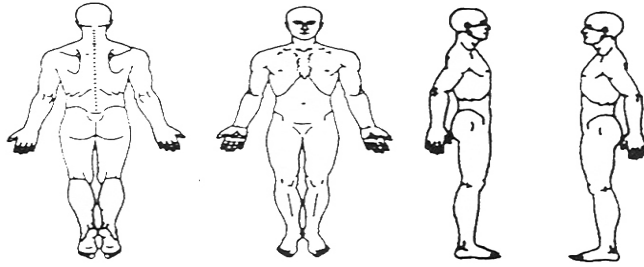
DOCTOR'S NOTES:

C. Complete the box below and check all boxes that apply OR if this section does not apply to your health history, check here _____ and proceed to next section.

D. Complete the box below and check all boxes that apply OR if this section does not apply to your health history, check here _____ and proceed to next section.

C. MID BACK / SHOULDER BLADES

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

- 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE

WHEN DID YOUR SYMPTOMS START?

HOW DID YOUR SYMPTOMS BEGIN?

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- CONSTANTLY (76%-100% OF THE DAY) FREQUENTLY (51%-75% OF THE DAY)
 OCCASIONALLY (26%-50% OF THE DAY) INTERMITTENTLY (0%-25% OF THE DAY)

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- DULL SHARP SHARP WITH MOVEMENT THROBING
 BURNING DEEP ACHING TINGLING
 STABBING CRAMPING PINPRICK NUMBNESS

DOES YOUR PAIN RADIATE? YES NO
IF YES, WHERE?

ARE YOUR SYMPTOMS:

- THE SAME ALL THE TIME
 WORSE: A.M. MIDDAY P.M. AT NIGHT AT NIGHT WITH PAIN
 BETTER: A.M. MIDDAY P.M. AT NIGHT AT NIGHT WITH PAIN

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?

- SITTING STANDING WALKING BENDING
 STAIR STEPPING LIFTING SLEEPING SNEEZING
 LOOKING UP STRAINING REACHING TWISTING
 LOOKING DOWN COUGHING MOVEMENT REST
 LYING SUPINE DRIVING TYPING SCOOPING
 HOUSEHOLD CHORES EXERCISE STOOPING OTHER: _____

WHAT RELIEVES YOUR SYMPTOMS?

- SITTING STANDING LYING DOWN
 LEANING AGAINST A SUPPORT NO MOVEMENT MOVEMENT
 HEAT IS APPLIED ICE IS APPLIED REST OCCURS
 ADVIL/TYLENOL IS TAKEN R/x MEDICATION ADJUSTMENTS
 TOPICAL PAIN RELIEF GEL STRETCHING EXERCISE
 OTHER: _____

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? YES NO

IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED OTHER PHYSICIANS FOR YOUR SYMPTOMS? YES NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?

- NONE X-RAYS MRI CT SCAN OTHER: _____

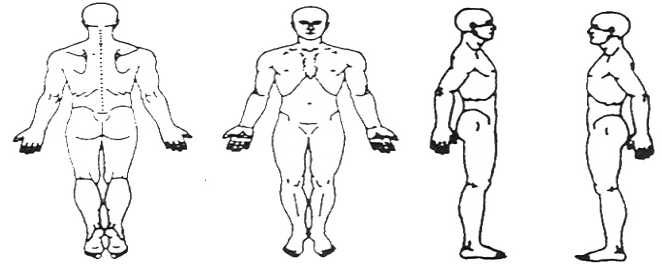
IF YES, WHEN AND WHERE:

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO
IF YES, WHEN:

DOCTOR'S NOTES:

D. LOWER BACK / LOWER EXTREMITIES (LEGS/FEET)

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

- 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE

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HOW DID YOUR SYMPTOMS BEGIN?

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 LOOKING UP STRAINING REACHING TWISTING
 LOOKING DOWN COUGHING MOVEMENT REST
 LYING SUPINE DRIVING TYPING SCOOPING
 HOUSEHOLD CHORES EXERCISE STOOPING OTHER: _____

WHAT RELIEVES YOUR SYMPTOMS?

- SITTING STANDING LYING DOWN
 LEANING AGAINST A SUPPORT NO MOVEMENT MOVEMENT
 HEAT IS APPLIED ICE IS APPLIED REST OCCURS
 ADVIL/TYLENOL IS TAKEN R/x MEDICATION ADJUSTMENTS
 TOPICAL PAIN RELIEF GEL STRETCHING EXERCISE
 OTHER: _____

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? YES NO

IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED OTHER PHYSICIANS FOR YOUR SYMPTOMS? YES NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?

- NONE X-RAYS MRI CT SCAN OTHER: _____

IF YES, WHEN AND WHERE:

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO
IF YES, WHEN:

DOCTOR'S NOTES:

MEDICAL CONDITIONS	
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> CANCER TYPE: _____	<input type="checkbox"/> PSYCHIATRIC ILLNESS
<input type="checkbox"/> DIABETES	<input type="checkbox"/> SKIN DISORDER
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> STROKE

SURGERIES (Check and List year)	
<input type="checkbox"/> APPENDECTOMY _____	<input type="checkbox"/> JOINT REPLACEMENT _____
<input type="checkbox"/> HEART _____	<input type="checkbox"/> NECK SURGERY _____
<input type="checkbox"/> LAMINECTOMIES _____	<input type="checkbox"/> BACK SURGERY _____
<input type="checkbox"/> PROSTATE SURGERY _____	<input type="checkbox"/> HYSTERECTOMY _____
<input type="checkbox"/> OTHER (DESCRIBE): _____	

ALLERGIES	
<input type="checkbox"/> EGGS	<input type="checkbox"/> SOY
<input type="checkbox"/> FISH AND SHELLFISH	<input type="checkbox"/> SULFITES
<input type="checkbox"/> MILK OR LACTOSE	<input type="checkbox"/> WHEAT/GLUTEN
<input type="checkbox"/> PEANUT	<input type="checkbox"/> OTHER: _____

SOCIAL HISTORY	
<input type="checkbox"/> CAFFEINE USED OCCASIONALLY	<input type="checkbox"/> CAFFEINE USED OFTEN
<input type="checkbox"/> CHEW TOBACCO OCCASIONALLY	<input type="checkbox"/> CHEW TOBACCO OFTEN
<input type="checkbox"/> DRINK ALCOHOL OCCASIONALLY	<input type="checkbox"/> DRINK ALCOHOL OFTEN
<input type="checkbox"/> EXERCISE NOT AT ALL	<input type="checkbox"/> EXERCISE OCCASIONALLY
<input type="checkbox"/> EXERCISE OFTEN	<input type="checkbox"/> EXPERIENCE STRESS OCCASIONALLY
<input type="checkbox"/> EXPERIENCE STRESS OFTEN	<input type="checkbox"/> WEAR SEAT BELTS ALWAYS
<input type="checkbox"/> WEAR SEAT BELTS NEVER	<input type="checkbox"/> WEAR SEAT BELTS USUALLY

SUBSTANCE ABUSE	
<input type="checkbox"/> ALCOHOL (PAST)	<input type="checkbox"/> ALCOHOL (PRESENT)
<input type="checkbox"/> AMPHETAMINES (PAST)	<input type="checkbox"/> AMPHETAMINES (PRESENT)
<input type="checkbox"/> BARBITUATES (PAST)	<input type="checkbox"/> BARBITUATES (PRESENT)
<input type="checkbox"/> COCAINE (PAST)	<input type="checkbox"/> COCAINE (PRESENT)
<input type="checkbox"/> CRYSTAL METH (PAST)	<input type="checkbox"/> CRYSTAL METH (PRESENT)
<input type="checkbox"/> HEROINE (PAST)	<input type="checkbox"/> HEROINE (PRESENT)
<input type="checkbox"/> MARIJUANA (PAST)	<input type="checkbox"/> MARIJUANA (PRESENT)

OCCUPATIONAL ACTIVITIES	
<input type="checkbox"/> BUSINESS OWNER	<input type="checkbox"/> COMPUTER/ADMINISTRATIVE
<input type="checkbox"/> EXECUTIVE/LEGAL	<input type="checkbox"/> FOOD SERVICES
<input type="checkbox"/> HEALTHCARE/HOMESERVICES	<input type="checkbox"/> CONSTRUCTION/LABORER
<input type="checkbox"/> HOUSHOLD	<input type="checkbox"/> OTHER: _____

RECREATIONAL ACTIVITIES	
<input type="checkbox"/> BACKPACKING	<input type="checkbox"/> BOATING
<input type="checkbox"/> GOLF	<input type="checkbox"/> RUNNING
<input type="checkbox"/> SOCCER	<input type="checkbox"/> TENNIS
<input type="checkbox"/> WEIGHT LIFTING	<input type="checkbox"/> FOOTBALL
<input type="checkbox"/> BIKING	<input type="checkbox"/> SKIING
<input type="checkbox"/> RACQUETBALL	<input type="checkbox"/> WALKING
<input type="checkbox"/> SWIMMING	<input type="checkbox"/> OTHER: _____

WOMEN ONLY	
ARE YOU PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES DUE DATE: _____	
IF PREGNANT IN PAST, WERE PREGNANCIES NORMAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ARE YOU SEEING AN OB-GYN REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
# OF BIRTHS: _____	DATE OF LAST EXAM: _____
PHYSICIAN'S NAME & ADDRESS: _____	

FAMILY HISTORY (Check appropriate boxes if they affected that person.)					
	<u>FATHER</u>	<u>MOTHER</u>	<u>BROTHERS</u>	<u>SISTERS</u>	<u>CHILDREN</u>
ADOPTED, UNKOWN HISTORY					
ANEMIA					
ARTHRITIS					
BACK / DISC PROBLEMS					
CANCER					
CHOLESTEROL					
CONGENITAL DEFECTS					
DIABETES					
GENETIC DISEASE					
HEADACHES					
HEART TROUBLE					
HIGH BLOOD PRESSURE					
JOINT PROBLEMS					
KIDNEY DISEASE					
MENTAL ILLNESS					
MULTIPLE SCLEROSIS					
OSTEOPOROSIS					
PHSYCHIATRIC					
SCOLIOSIS					
STROKE					
THYROID					
DECEASED					
OTHER: _____					

REVIEW OF SYSTEMS

If you are having any of these symptoms currently (less than 4 weeks) check present or if greater than 4 weeks check past.

CARDIOVASCULAR

POOR CIRCULATION
HIGH BLOOD PRESSURE
AORTIC ANEURYSM
HEART DISEASE
HEART ATTACK
CHEST PAIN
HIGH CHOLESTEROL
PACE MAKER
JAW PAIN
IRREGULAR HEARTBEAT
SWELLING OF LEGS

PRESENT	PAST

GENITOURINARY

KIDNEY DISEASE
LOWER SIDE PAIN
BURNING URINATION
FREQUENT URINATION
BLOOD IN URINE
KIDNEY STONE

PRESENT	PAST

HEMATOLOGIC/ LYMPHATIC

HEPATITIS
BLOOD CLOTS
CANCER
EASY BRUISING
EASY BLEEDING
FEVERS/CHILLS/SWEATS

PRESENT	PAST

RESPIRATORY

ASTHMA
TUBERCULOSIS
SHORTNESS OF BREATH
EMPHYSEMA
COLD/FLU
COUGH/WHEEZING
BRONCHITIS
PNEUMONIA

PRESENT	PAST

EARS/ NOSE/ THROAT

DIZZINESS
HEARING LOSS
SINUS INFECTION
NOSEBLEED
SORE THROAT
DIFFICULTY SWALLOWING
BLEEDING GUMS
EAR INFECTION

PRESENT	PAST

EYES

GLAUCOMA
DOUBLE VISION
BLURRED VISION

PRESENT	PAST

INTEGUMENTARY

SKIN ULCERS
SKIN DISEASE
ECZEMA
PSORIASIS
RASHES

PRESENT	PAST

ALLERGIC/ IMMUNOLOGIC

HIVES
IMMUNE DISORDER
HIV/AIDS
ALLERGY SHOTS
ALLERGY MEDS
CORTISONE USE

PRESENT	PAST

GASTROINTESTINAL

GALLBLADDER PROBLEMS
BOWEL PROBLEMS
CONSTIPATION
LIVER PROBLEMS
ULCERS
DIARRHEA
NAUSEA/VOMITING
BLOODY STOOLS
POOR APPETITE

PRESENT	PAST

MUSCULOSKELETAL

GOUT
ARTHRITIS
JOINT STIFFNESS
MUSCLE WEAKNESS
OSTEOPOROSIS
BROKEN BONES
JOINTS REPLACED

PRESENT	PAST

ENDOCRINE

THYROID DISEASE
DIABETES
HAIR LOSS
MENOPAUSAL
MENSTRUAL PROBLEMS

PRESENT	PAST

PSYCHIATRIC

DEPRESSION
ANXIETY DISORDER
UNUSUAL STRESS

PRESENT	PAST

CONSTITUTIONAL

WEIGHT LOSS/GAIN
ENERGY LEVEL PROBLEM
DIFFICULTY SLEEPING

PRESENT	PAST

NEUROLOGIC

STROKE
SEIZURES
HEAD INJURY
BRAIN ANEURYSM
NUMBNESS
SEVERE HEADACHES
PINCHED NERVES
PARKINSONS DISEASE
CARPAL TUNNEL
SPINNING/BALANCE

PRESENT	PAST

HEALTH HISTORY

PLEASE LIST ANY ACCIDENT (AUTO/WORK/OTHER), INJURIES OR FALLS YOU HAD IN THE PAST:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO
(PLEASE LIST CURRENT MEDICATIONS AND DOSAGE)

MEDICATION /DOSAGE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ARE YOU CURRENTLY TAKING ANY VITAMINS, MINERALS, OR HERBS? YES NO
(PLEASE LIST CURRENT SUPPLEMENTS AND DOSSAGE)

SUPPLEMENT/DOSAGE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO (LIST ANY KNOWN ALLERGIES THAT YOU HAVE TO MEDICATIONS)

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

HAS ANY DOCTOR DIAGNOSED YOU WITH HYPERTENSTION PRESENTLY? YES NO

IF YES, WHAT KIND?

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 > 90%? YES NO

HAS ANY DOCTOR DIAGNOSED YOU WITH ANY TYPE OF SIGNIFICANT HEALTH SYNDROM PRESENTLY? YES NO NOT SURE

IF YES, WHAT KIND?

DO YOU CURRENTLY SMOKE TOBACCO OF ANY KIND? YES NEVER BEEN A SMOKER FORMER SMOKER

IF YES, HOW OFTEN DO YOU SMOKE: CURRENT EVERDAY SMOKER CURRENT SOMDAY SMOKER

IF YES, WHAT IS YOUR LEVEL OF INTEREST IN QUITTING SMOKING? 0 1 2 3 4 5 6 7 8 9 10 N/A

RELEASE OF INFORMATION

I _____ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

Form with fields for NAME, RELATIONSHIP, ADDRESS, CITY, STATE, ZIP, and PHONE for two individuals.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she 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 hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office.

Correspondence Authorization: By providing your e-mail you are accepting to receive correspondence regarding your care.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understand both the objective and the method that will be able to attain it.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities.

- You may request restrictions on your disclosures.
You may inspect and receive copies of your records within 30 days with a request.
You may request to view changes to your records.
In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Form with fields for SIGNATURE, WITNESS SIGNATURE, GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE, and DATE.

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?
[PATIENT] [SPOUSE] [PARENT] [WORKERS COMP] [AUTO INSURANCE] [MEDICARE] [HEALTH INSURANCE]