CONFIDENTIAL HEALTH HISTORY

This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

PERSONAL:

Name: _____ Sex: M ☐ F ☐ Marital Status: M ☐ S ☐ W ☐ D ☐ Date of Birth: ____ ____ ____ (month / day / year) Home Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Who referred you to our office? _____ Occupation: _____
(If student, unemployed, retired, child, housewife, etc., please so indicate)

Social Sec. #: _____ Business Phone: (_____)_____ Company Name: _____ Location: _____

Spouse's First name: _____ Spouse's Soc. Sec. #: _____ Spouse's Employer: _____ Location: _____

HEALTH REPORT:

Is this visit for an annual physical? ☐ Yes ☐ No Height: Feet _____ Inches _____ Weight: _____

Please describe the principal health problems for which you came to this office: _____

List any other doctors seen for this: _____

List diagnosis(es) and type of treatment(s): _____

Have you lost any days of work? ☐ Yes ☐ No Dates: _____

Have you had similar accidents or injuries before: ☐ Yes ☐ No If yes, explain: _____

List the names of any relatives that have or have had a similar problem: _____

Have you or any relative received chiropractic treatment previously? ☐ Yes ☐ No If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No If yes, explain: _____

List the approximate dates of any operations or unusual diseases you have had: _____

If your condition is due to an accident, not work related, please answer the following:

Date _____ Time _____ AM _____ PM _____ of accident. Police report made? ☐Yes ☐ No When? _____

Place — Location of accident: _____

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No If yes, list the name and address: _____

Please describe the accident: _____

If your condition is due to a work-related accident, please answer the following:

Have you notified your employer? ☐ Yes ☐ No If yes, who or what department? _____

Date injured _____ Time _____ AM _____ PM _____ Date last worked _____

Injured at: _____
(Address, city, county, state, zip)

— OVER —

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of one of the following codes:
Codes: 1 for **never** had; 2 for **previously** had; 3 for **presently** have.

MUSCULO-SKELETAL SYSTEM

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

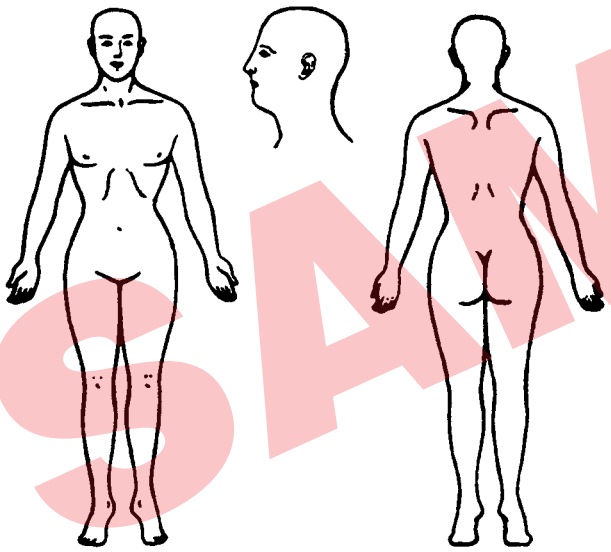
GENITO-URINARY SYSTEM

___ Bladder trouble
___ Excessive urine
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW.



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO-VASCULAR-RESPIRATORY

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYE, EAR, NOSE AND THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficult breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

If you have insurance coverage, we will process your claim; but you must collect from your insurance company. Give this information to the receptionist.

I understand that all treatments, X-rays and laboratory examinations are to be paid for as they are received or definite financial arrangements made in advance.

_____

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

Patient accepted? Yes☐ No ☐ Date _____ Doctor's signature _____