(1) CONFIDENTIAL HISTORY **All Information is Confidential (2024)**

Date_________________________________ **PLEASE USE INK TO FILL OUT**

Patient's Name____

Address____

City____ State________ Zip__________

Birthdate_________________ Age_________ Race __XXXX Ethnicity XXXX____

Marital Status S M D W Number of Children ____________

Cell Number ________________________________ Home Number ________________________

Cell Phone Provider __________________________

Email Address ____

Preferred method of contact? Cell Phone Home phone Email

Employer__________________________________Occupation_____________________________

Address____

City____ State________ Zip__________

Phone ________________________ May we contact your at work? Yes No

Name of Spouse_________________________________ Birthdate_______________________

Employer____

Phone _________________________ Occupation_________________________________

Emergency Contact _____________________________ Phone _________________________

Address___________________________ City______________ State_______ Zip_______

Whom may we thank for referring you?____

Location Sign Website Other ______________________________

We do not file insurance; however, we are required to have copies of Driver's License and Insurance Cards in your file. **Please allow us to copy your Driver's License and Insurance Card.**

(2) SUBJECTIVE HISTORY **Patient's Name**________________________________

#1 (Primary Reason for today's appt)____

____

When did you first notice your current symptoms?________________________________

Rate your symptoms on a scale of 1-10 ____________________________________

How often do you feel it? Constant Intermittent ______________________________

Is this an ongoing or recurring problem? New Ongoing Recurring

Explain____

What **AGGRAVATES** this symptom?____

What are you **UNABLE TO DO** because of this symptom?_____________________________

What have you done to **RELIEVE** this symptom? ___________________________________

#2(Secondary Reason for today's appt) ____

____

When did you first notice your current symptoms?________________________________

Rate your symptoms on a scale of 1-10 ____________________________________

How often do you feel it? Constant Intermittent ______________________________

Is this an ongoing or recurring problem? New Ongoing Recurring

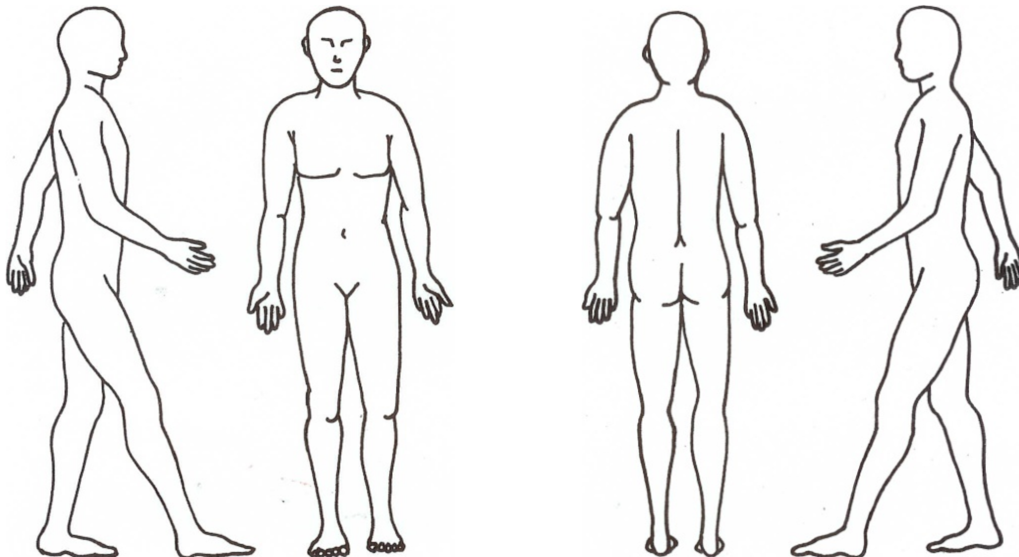
Explain____

What **AGGRAVATES** this symptom?____

What are you **UNABLE TO DO** because of this symptom?_____________________________

What have you done to **RELIEVE** this symptom? ___________________________________

COLOR ANY PAIN IN RED **COLOR ANY NUMBNESS OR TINGLING IN BLUE**



CIRCLE all that apply to your current symptoms. **Quality** of symptoms (What does it feel like?)

Sharp	Shooting	Stabbing	Aching	Dull
Stiffness	Tightness	Tingling	Numbness	

Patient's Name________________________________

TREATMENT BY OTHER DOCTORS FOR YOUR CURRENT SYMPTOMS/PROBLEMS

TESTS AND/OR PROCEDURES	DATE OF TEST	NAME OF DOCTOR

ACTIVITIES OF DAILY LIVING

How do your symptoms interfere with your ability to function? **Circle or check whichever applies:**

Activity			
Getting out of a chair	Mild	Moderate	Severe
Getting in/out of car	Mild	Moderate	Severe
Going up/down stairs	Mild	Moderate	Severe
Standing	Mild	Moderate	Severe
Walking	Mild	Moderate	Severe
Bending over	Mild	Moderate	Severe
Exercising	Mild	Moderate	Severe
Household chores	Mild	Moderate	Severe
Lifting objects	Mild	Moderate	Severe
Reaching overhead	Mild	Moderate	Severe
Showering or bathing	Mild	Moderate	Severe
Dressing myself	Mild	Moderate	Severe
Lying down	Mild	Moderate	Severe
Getting to sleep	Mild	Moderate	Severe
Staying asleep	Mild	Moderate	Severe

CURRENT MEDICATIONS

Please list all medications you are taking. Include prescribed drugs and over-the-counter drugs, vitamins etc.

Drug Name/Strength	Frequency	Name of Doctor prescribed
mg		
mg		
mg		
mg		
mg		

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc) and how each affects you

Allergy	Reaction

Patient's Name________________________________

PAST MEDICAL HISTORY (Please check all that apply)

_______ AIDS or HIV
_______ Alcoholism
_______ Arthritis
_______ Blood Clots
_______ Blood in Urine/Stools
_______ Cancer
_______ Coronary Artery Disease
_______ Coughing up Blood
_______Cramping Legs/Arms
_______ Diabetes-Insulin
_______ Diabetes-Non-Insulin
_______ Difficulty Breathing-Asthma
_______ Diverticulitis
_______ Double Vision
_______ Fibromyalgia
_______ Gout
_______ Heart Attack
_______ Heart Problems
_______ Hiatal Hernia
_______ High Blood Pressure
_______ High Cholesterol
_______ Irritable Bowel
_______ Kidney Disease
_______ Leg/Foot Ulcers
_______ Liver Disease
_______ Loss Bladder/Bowel Control
_______ Lost Consciousness
_______ Lost/Gained Weight
_______ Osteoporosis
_______ Polio
_______ Pulmonary Embolism
_______ Reflux or Ulcers
_______ Sleeping Disorder
_______ Stroke
_______ Thyroid Hyper/Hypo

PAST SURGICAL HISTORY

SURGERY/Year performed	REASON FOR THE SURGERY

SOCIAL HISTORY

ALCOHOL USE

_______ None
_______ Casual drinker
_______ Moderate drinker
_______ Heavy drinker

TOBACCO USE

_______ Never Smoker
_______ Current every day smoker
_______ Current some day smoker
_______ Former Smoker

DRUG USE

Do you currently use street drugs?

Yes No

If yes, please list

____

FAMILY HISTORY

Relative	Age (if living)	Illnesses	Cause of death
Mother			
Father			
Sister 1			
Sister2			
Brother 1			
Brother 2			

Patient's Name________________________________

OTHER HEALTH FACTS Please add other information about your health that you would like the Doctor to know here: ____
____
____
______

ACKNOWLEDGEMENTS Please read each statement and initial your agreement.

X_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care.

X_____ It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private confidential setting.

X_____To the best of my ability, the information I have supplied is complete and truthful.

This office does not file insurance claims with any insurance company including Medicare and Medicare Advantage. I accept responsibility for payment for all services rendered. Any balance unpaid after thirty (30) days from the last date of service, will be subject to a $5 billing fee or finance charges of 2.5% per month. Furthermore, I will be responsible for all costs of collection including reasonable attorney fees.

X ____________________________________ ___________________________
Signature Date