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**(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

(3) 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:**

 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

(4) Patient’s Name

**PAST MEDICAL HISTORY** (Please check all that apply)

 AIDS or HIV Diverticulitis Leg/Foot Ulcers

 Alcoholism Double Vision Liver Disease

 Arthritis Fibromyalgia Loss Bladder/Bowel Control

 Blood Clots Gout Lost Consciousness

 Blood in Urine/Stools Heart Attack Lost/Gained Weight

 Cancer Heart Problems Osteoporosis

 Coronary Artery Disease Hiatal Hernia Polio

 Coughing up Blood High Blood Pressure Pulmonary Embolism

 Cramping Legs/Arms High Cholesterol Reflux or Ulcers

 Diabetes-Insulin Irritable Bowel Sleeping Disorder

 Diabetes-Non-Insulin Kidney Disease Stroke

 Difficulty Breathing-Asthma Thyroid Hyper/Hypo

**PAST SURGICAL HISTORY**

SURGERY/Year performed REASON FOR THE SURGERY

**SOCIAL HISTORY**

**ALCOHOL USE TOBACCO USE DRUG USE**

 None Never Smoker Do you currently use street drugs?

 Casual drinker Current every day smoker Yes No

 Moderate drinker Current some day smoker If yes, please list

 Heavy drinker Former Smoker

**FAMILY HISTORY**

Relative Age (if living) Illnesses Cause of death

Mother

Father

Sister 1

Sister2

Brother 1

Brother 2

(5) 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