Miskelly Chiropractic Center, P.C.

(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

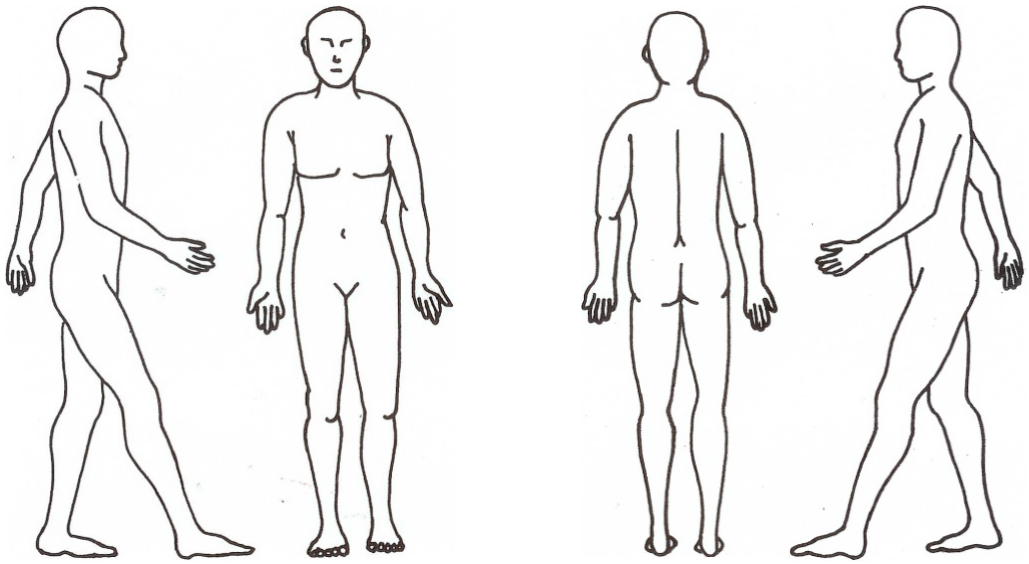
Explain

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:**

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			

(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