

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

confidential health information

1 PATIENT INFORMATION

last name		clinic id	date
first name	m.i.		

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? yes no

What services interest you? (mark all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> injury prevention | <input type="checkbox"/> treatment for pain | <input type="checkbox"/> patient education classes |
| <input type="checkbox"/> balance and coordination training | <input type="checkbox"/> spinal and body alignment | <input type="checkbox"/> body composition counseling |
| <input type="checkbox"/> range of motion, mobility, or flexibility therapy | <input type="checkbox"/> strengthening and stamina exercise | <input type="checkbox"/> nutritional and supplement counseling |
- other: _____

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? dull/achy sharp numb tingling burning cold

How often do you experience the **primary** complaint? constantly daily weekly monthly yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1 no pain or discomfort	2 slight discomfort	3 pain that does not affect my activity	4 pain that affects my daily activities	5 pain that prevents performing my daily activities	6 pain that limits my work schedule	7 pain that prevents working at all	8 pain that prevents working and all personal activity	9 pain that keeps me bed ridden	10 pain that causes thoughts of suicide
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If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

2	4
3	5

Do you have any other condition other than what brings you here? yes no

If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.



3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day? < 1 1-3 3-5 >5

Do you usually snack while watching television? yes no

How many hours per day do you use a computer at work or home? < 1 1-3 3-5 >5

How many hours per day do you ride in a car or other vehicle? < 1 1-3 3-5 >5

How often do you exercise? daily 3x's/week 2x's/week 1x/week I don't exercise

How long do your exercise work outs last? >1 hour 1 hour 30 minutes < 30 minutes NA

What are your exercise activities? (mark all that apply) I don't exercise

- | | | |
|--|---|---|
| <input type="checkbox"/> walking | <input type="checkbox"/> swimming | <input type="checkbox"/> weight lifting |
| <input type="checkbox"/> stretching/flexibility | <input type="checkbox"/> yoga/Pilates | <input type="checkbox"/> resistance bands |
| <input type="checkbox"/> running/treadmill/rowing/climbing | <input type="checkbox"/> group exercise classes | <input type="checkbox"/> other _____ |

Do you take a multi-vitamin? yes no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tobacco? never daily weekly monthly yearly

How many servings of alcohol do you drink each week? 0 1-2 3-5 >5

How many servings of coffee do you drink each week? 0 1-2 3-5 >5

How many servings of soda do you drink each week? 0 1-2 3-5 >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
heart problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
kidney problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
cancer	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
headaches	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
back pain	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
obesity	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
poor conditioning	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	low back pain	<input type="checkbox"/> yes <input type="checkbox"/> no	polio	<input type="checkbox"/> yes <input type="checkbox"/> no
anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	goiter	<input type="checkbox"/> yes <input type="checkbox"/> no	measles	<input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	mental disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV positive	<input type="checkbox"/> yes <input type="checkbox"/> no	mumps	<input type="checkbox"/> yes <input type="checkbox"/> no	venereal infection	<input type="checkbox"/> yes <input type="checkbox"/> no
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	influenza	<input type="checkbox"/> yes <input type="checkbox"/> no	pleurisy	<input type="checkbox"/> yes <input type="checkbox"/> no	whiplash	<input type="checkbox"/> yes <input type="checkbox"/> no
				pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough	<input type="checkbox"/> yes <input type="checkbox"/> no

6 INJURIES

patient name

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? yes no

Have you had knee or hip replacement surgery? yes no

Do you have a pacemaker? yes no

Do you have any other implantable medical devices in your body? yes no

Mark all of the following procedures as they pertain to you.

vaccinations	<input type="checkbox"/> yes <input type="checkbox"/> no	tubes in ears	<input type="checkbox"/> yes <input type="checkbox"/> no	rectal surgery	<input type="checkbox"/> yes <input type="checkbox"/> no
tonsillectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	appendectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	sinus surgery	<input type="checkbox"/> yes <input type="checkbox"/> no
gall bladder removal	<input type="checkbox"/> yes <input type="checkbox"/> no	female/male surgery	<input type="checkbox"/> yes <input type="checkbox"/> no	hernia surgery	<input type="checkbox"/> yes <input type="checkbox"/> no
back surgery	<input type="checkbox"/> yes <input type="checkbox"/> no			thyroid surgery	<input type="checkbox"/> yes <input type="checkbox"/> no
				stomach surgery	<input type="checkbox"/> yes <input type="checkbox"/> no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? yes no Were you ever knocked unconscious? yes no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? yes no

8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you.

General

<input type="checkbox"/> consistent fainting	<input type="checkbox"/> chills	<input type="checkbox"/> convulsions	<input type="checkbox"/> depression	<input type="checkbox"/> dizziness
<input type="checkbox"/> loss of weight	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> headache	<input type="checkbox"/> loss of sleep
<input type="checkbox"/> weight gain	<input type="checkbox"/> neuralgia	<input type="checkbox"/> night sweats	<input type="checkbox"/> wheezing	<input type="checkbox"/> nervousness

Gastro-Intestinal

<input type="checkbox"/> constipation	<input type="checkbox"/> diarrhea	<input type="checkbox"/> gall bladder problems	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> jaundice
<input type="checkbox"/> liver problems	<input type="checkbox"/> nausea	<input type="checkbox"/> stomach pain	<input type="checkbox"/> poor appetite	<input type="checkbox"/> poor digestion
<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> vomiting	<input type="checkbox"/> vomiting blood		

Eye/Ear/Nose/Throat

<input type="checkbox"/> asthma	<input type="checkbox"/> crossed eyes	<input type="checkbox"/> deafness	<input type="checkbox"/> earache	<input type="checkbox"/> ear discharge
<input type="checkbox"/> ear noises	<input type="checkbox"/> enlarged thyroid	<input type="checkbox"/> frequent colds	<input type="checkbox"/> hay fever	<input type="checkbox"/> hoarseness
<input type="checkbox"/> nasal obstruction	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> pain in eyes	<input type="checkbox"/> poor vision	<input type="checkbox"/> sinusitis
<input type="checkbox"/> sore throat	<input type="checkbox"/> tonsillitis			

Respiratory

<input type="checkbox"/> chest pain	<input type="checkbox"/> chronic cough	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> spitting blood	<input type="checkbox"/> spitting phlegm
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Muscles/Joints/Bones

<input type="checkbox"/> backache	<input type="checkbox"/> foot problems	<input type="checkbox"/> pain bet. shoulders	<input type="checkbox"/> painful tailbone	<input type="checkbox"/> stiff neck
<input type="checkbox"/> spinal curvature	<input type="checkbox"/> swollen joints	<input type="checkbox"/> tremors	<input type="checkbox"/> twitching	<input type="checkbox"/> weakness

Cardio-Vascular

<input type="checkbox"/> ankle swelling	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> heart trouble	<input type="checkbox"/> pain over heart
<input type="checkbox"/> poor circulation	<input type="checkbox"/> rapid heart	<input type="checkbox"/> slow heart	<input type="checkbox"/> strokes	

Skin or Allergies

<input type="checkbox"/> bruise easily	<input type="checkbox"/> dryness	<input type="checkbox"/> eczema	<input type="checkbox"/> hives	<input type="checkbox"/> itching
<input type="checkbox"/> sensitive skin				

Women

<input type="checkbox"/> cramps	<input type="checkbox"/> excessive flow	<input type="checkbox"/> hot flashes	<input type="checkbox"/> irregular cycle	<input type="checkbox"/> painful periods
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9 PREGNANCY

WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? yes no On what date did your last period begin?

Do you want to take a pregnancy test now? yes no

OFFICE USE ONLY

result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation	<input type="checkbox"/> yes <input type="checkbox"/> no	complete or partial hysterectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	partner had a vasectomy	<input type="checkbox"/> yes <input type="checkbox"/> no
less than 10 days since the start of my last period	<input type="checkbox"/> yes <input type="checkbox"/> no	taking birth control pills	<input type="checkbox"/> yes <input type="checkbox"/> no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date