Carpenter Family Chiropractic

HEALTH ANALYSIS

No:______________________ Date:______________________

Patient: ______________________ Home Phone (____)______________

Address______________________City______________State__________Zip__________

Marital Status: ☐ Single ☐ Married ☐Widowed ☐ Separated ☐ Divorced

Age__________ Occupation______________________

Please Circle the Appropriate Answer

1.	Do you need glasses to read?	Yes	No
2.	Do you need glasses to see things at a distance?	Yes	No
3.	Has your eyesight often blacked out completely?	Yes	No
4.	Do you often have bad pains in your eyes?	Yes	No
5.	Are your eyes often red or inflamed?	Yes	No
6.	Are you hard of hearing?	Yes	No
7.	Have you ever had a fluid leaking from your ear?	Yes	No
8.	Do you have constant noises in your ears?	Yes	No
9.	Do you have to clear your throat constantly?	Yes	No
10.	Do you often feel a choking lump in your throat?	Yes	No
11.	Are you often troubled with bad spells of sneezing?	Yes	No
12.	Is your nose continually stuffed up?	Yes	No
13.	Do you suffer from a constantly running nose?	Yes	No
14.	Have you at times had bad nose bleeds?	Yes	No
15.	Do you frequently suffer from heavy chest colds?	Yes	No
16.	Do you get hay fever?	Yes	No
17.	Do you suffer from asthma?	Yes	No
18.	Are you troubled by constant coughing?	Yes	No
19.	Have you ever coughed up blood?	Yes	No
20.	Do you wake up drenched with swat during the middle of the night?	Yes	No
21.	Have ever had a chronic chest condition?	Yes	No
22.	Has a doctor ever said your blood pressure was too high?	Yes	No
23.	Has a doctor ever said your blood pressure was too low?	Yes	No
24.	Do you have pains in the heart or chest?	Yes	No
25.	Are you often bothered by thumping of the heart?	Yes	No
26.	Does your heart often race like mad?	Yes	No
27.	Do you often have difficulty in breathing?	Yes	No
28.	Are your ankles often badly swollen?	Yes	No
29.	Do cold hands or feet trouble you, even in hot weather?	Yes	No
30.	Do you suffer from frequent cramps in your legs?	Yes	No
31.	Has a doctor ever said you had heart trouble?	Yes	No
32.	Does heart trouble run in your family?	Yes	No
33.	Do severe pains in the stomach often cause you to double over?	Yes	No
34.	Do you suffer from constant stomach trouble?	Yes	No
35.	Does stomach trouble run in your family?	Yes	No
36.	Has a doctor ever said you had stomach ulcers?	Yes	No
37.	Do you suffer from frequent loose bowel movements?	Yes	No
38.	Have you ever had sever bloody diarrhea?	Yes	No
39.	Do you constantly suffer from bad constipation?	Yes	No
40.	Do you usually feel bloated after eating?	Yes	No
41.	Are your joints often painfully swollen?	Yes	No

42. Do your muscles and joints constantly feel stiff? .... Yes No
43. Do you usually have severe pains in the arms or legs? .... Yes No
44. Are you crumpled with severe arthritis? .... Yes No
45. Does arthritis run in your family? .... Yes No
46. Do weak or painful feet make your life miserable? .... Yes No
47. Do pains in the back make it hard for you to keep up with your work? .... Yes No
48. Are you troubled with a serous bodily disability or deformity? .... Yes No

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49. Do you suffer from frequent severe headaches? .... Yes No
50. Does pressure or pain in the head often make life miserable? .... Yes No
51. Are headaches common in your family? .... Yes No
52. Do you often have spells or severe dizziness? .... Yes No
53. Do you frequently feel faint? .... Yes No
54. Have you faint more than twice in your life? .... Yes No
55. Do you have constant numbness or tingling in any part of your body? .... Yes No
56. Were you ever knocked unconscious? .... Yes No
57. Have you at times had a twitching of the head, face or shoulders? .... Yes No
58. Did you ever have a seizure or convulsion (epilepsy)? .... Yes No
59. Has anyone in your family ever had seizures or convulsion (epilepsy)? .... Yes No
60. Did a doctor ever treat you for a tumor or cancer? .... Yes No
61. Are you a sleep walker? .... Yes No
62. Are you a bed wetter? .... Yes No
63. Were a bed wetter between the ages of 8 to 14?.................................... Yes No
64. Are you crippled with severe arthritis?.................................... Yes No
65. During the day, do you unusually have to urinate frequently?.................................... Yes No
66. Do you often have sever burning when you urinate?.................................... Yes No
67. Do you sometimes lose control or your bladder?.................................... Yes No
68. has a doctor ever said you had a kidney or bladder disease?.................................... Yes No

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Women only…Are you pregnant? ***Yes*** ***No***

70. Have your menstrual periods usually been painful?.................................... Yes No
71. Have you often felt weak or sick with your periods? .... Yes No
72. Have you often had to lie down when your periods came on? .... Yes No
73. Have you usually been tense or jumpy with your periods? .... Yes No
74. Have you ever had severe hot flashes or sweats? .... Yes No
75. Have you often been trouble with a vaginal discharge? .... Yes No

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Men Only…

76. Have you ever had anything wrong with your genitals? .... Yes No
77. Are your genitals often painful or sore? .... Yes No
78. Have you ever said you had a hernia (rupture)? .... Yes No
79. Have you ever passed blood while urinating? .... Yes No
80. Do you have trouble starting your stream when urinating? .... Yes No

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81. Does working tire you out completely?.................................... Yes No
82. Do you usually get up tired or exhausted in the morning? .... Yes No
83. Does every little effort wear you out? .... Yes No
84. Are you constantly too tired and exhausted to even eat? .... Yes No
85. Are you frequently confined to bed by illness? .... Yes No
86. Are you considered a sickly person? .... Yes No
87. Do severe pains and aches make it impossible for you to do your work? .... Yes No
88. Do you wear yourself out worrying about work? .... Yes No
89. Are you always ill and unhappy? .... Yes No

Carpenter Family Chiropractic

Chiropractic Case History

Name________________________ Sex M F Married___ Single___ Divorced___ Date__________

Address________________________ City ______________ State______ Zip__________

Home__________ Work__________ Cell __________ Date of Birth__________

Referred by________________________ Social Security #__________________

Occupation________________________ Employer__________________

Email ________________________ ☐ I would like to receive email notifications from this office.

Have you ever received Chiropractic Care? ☐Yes ☐ No If yes, when & by who?__________________

1. Primary reasons for seeking chiropractic care:

Primary reason: ____

Secondary reason: ____

Other factors contributing to the primary and secondary reasons: ______________________

2. Chief Complaint: ____

Location of Complaint: ____

Complaint Began when and how? ____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other ______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?__________________

Do you have any numbness or tingling in your body? Where? __________________

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? __________________

Does anything aggravate the complaint? __________________

Does anything make the complaint better? __________________

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: __________________

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4. Past Health History:

A. Previous illnesses you've had in your life: __________________

____

B. Previous injury or trauma: __________________

____

Have you ever broken any bones? Which? ____________________

C. **Allergies** ____________________

D. **Medications:**

Medication	Reason for taking

E. **Surgeries:**

Date	Type of Surgery

F. **Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? ____________________

5. **Family Health History:**

Associated health problems of relatives: ____________________

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. **Social and Occupational History:**

A. **Level of Education:**

O high school   O some college   O college graduate   O post graduate studies

B. **Job description:** ____________________

C. **Work schedule:** ____________________

D. **Recreational activities:** ____________________

E. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):** ____________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature ____________________ Date ____________

Doctor's Signature ____________________ Date ____________

Carpenter Chiropractic
110 W. Sandy Lake Rd. , Ste 128
Coppell, TX 75019 972-462-8282

Insurance Information and Assignment

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Carpenter Chiropractic will prepare and file any necessary forms as a courtesy to me. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. (Excluding PPO & HMO arrangements)

I hereby instruct and direct my insurance company to pay by check made out directly to Carpenter Chiropractic the professional or medical expenses benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. A photocopy of this assignment shall be considered as effective and valid as the original.

Date:____/____/____

Signature:____

Authorization To Treat A Minor Child

I hereby authorize the doctor to administer chiropractic care as deemed necessary to my child with or without parental attendance.

____
(Print child's name here)

Parent or Legal Guardian Signature:____________________________

Date:____/____/____