

COMMUNITY CHIROPRACTIC

563-359-4779

WELCOME TO OUR OFFICE

DATE: _____

HOW DID YOU HEAR ABOUT **COMMUNITY CHIROPRACTIC**, and/or, WHOM MAY WE THANK FOR REFERRING YOU? Person _____, **or** (circle one) Yellow Pages, Website, Signage/Drive By, Advertisement, Insurance Website

PATIENT INFO:

Last Name _____ First Name _____ Middle Initial _____

Gender: M F Date of Birth ____/____/____ Age ____ SS# _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

PHONE: Home _____ Cell _____ Work _____

Best Place to Reach You? (circle one) Home Cell Work

May we leave a voice message for you? (circle one) Yes No **If yes, where?** (circle one) Any Cell Home Work

Email address: _____

Status: (circle one) Married Single Divorced Widowed Separated Minor

Children's names and ages: _____

EMPLOYER:

Employer Name _____ Occupation _____ Length of Employment _____

Employer Address _____ Phone # _____

City _____ State _____ Zip Code _____

SPOUSE OR GUARDIAN: if applicable

Name _____ Phone # _____

Employer Name _____ Work Phone # _____

Date of Birth ____/____/____ SS# _____

EMERGENCY CONTACT: (if same as spouse/guardian circle YES)

Name _____ Relationship to Patient _____

Home phone # _____ Work Phone # _____

FINANCIAL RESPONSIBILITY:

Who is responsible for payment of this account? _____

Relationship to Patient? (self, parent, guardian) _____

How will you pay for your care? Cash Check Credit Card # _____ Exp. _____

PLEASE PRESENT YOUR INSURANCE CARD TO MAKE A PHOTO COPY: If we have a copy for your file you do not need to complete the following

Copy on file? YES Dr's Initials _____

Insurance Co _____ Phone # _____ ID # _____ Group Policy # _____

Insured's name _____ Insured's Employer _____

WHAT BRINGS YOU HERE

Have you had chiropractic care before? Yes No Where? Dr's Name? _____

If yes, was it for Current condition/problem Past/Other condition Wellness care/Health maintenance

When was your last chiropractic adjustment? _____

What condition did you receive care for? _____ Were you pleased with your care? YES NO

Did the treatment work? YES NO If yes, for how long? _____ Were X-Rays taken? YES NO

Is this appointment related to an accident? Yes No

If yes, what type of accident? work personal injury sports auto other _____

When did the incident occur? _____ Where did the incident occur? _____

To whom have you reported your accident? Auto Insurance Employer Worker Comp Other _____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from any other health professionals, for any reason? Yes No

If yes, is it for your current condition or something else? _____

Please indicate what kind of treatments you've received (shots, surgery, physical therapy, medication, other modalities etc...)

Please list any prescribed drugs or medications you are taking (If you have a list I can make a copy;bring it with you to your appt)

Please list any over-the-counter vitamins/herbs or anything else you are taking or using

Are you pregnant? Yes No If yes, what month _____ Is this your 1st pregnancy? Yes No

WHAT IS THE MAIN SYMPTOM/PROBLEM PROMPTING THIS OFFICE VISIT?

1.(MainComplaint)_____

2. (Secondary Complaint...if any)_____

How long have you had these symptoms/pain?_____

How often do you have these symptoms/pain?_____

Is it constant comes and goes

Is it getting worse getting better staying the same intermittent not sure

Do you have pain numbness tingling aches muscle spasms

cramps burning swelling stiffness other _____

Describe what it feels like (sharp, dull, throbbing, aching, stabbing, shooting etc)_____

Does the pain stay in one area (circle one) Y / N If it moves/travels tell me where it moves to _____

Do your symptoms interfere with

work sleep play day to day activities How so? _____

Any activities or movements that make it better? _____

For example sitting , standing , bending forward or backward , walking , lying in a certain position, weather , hand above head , other

Any activities or movements that make it worse? _____

For example sitting , standing , bending forward or backward , walking , lying in a certain position, weather , sneezing , coughing , other

YOUR HEALTH HISTORY/SOCIAL HISTORY/FAMILY HISTORY

Many health problems that occur later in life actually may have begun during earlier years and perhaps as far back as your developing years and birth. Please answer the following to the best of your ability and circle those that apply to you.

BIRTH HISTORY (Circle any that apply)

Mother smoked, drank, used drugs Forceps used Vacuum extraction used Complications
C-Section performed Home birth Unknown birth history

AGES 0 – 17 (Circle any that apply)

Vaccinations Antibiotics Alcohol/Drugs Smoker Emotional stress Other _____

AGES 18 – PRESENT (Circle and/or complete as requested)

Have you been a **SMOKER** at any time? **YES** **NO**
If **YES** was it? **PAST** **CURRENTLY**
If **PAST** smoker, how long did you smoke? _____ When did you quit? _____
If **CURRENTLY** a smoker, how long have you smoked? _____ When did you start? _____

WHAT SPORTS OR HOBBIES HAVE YOU PARTICIPATED IN?

Past: _____

Present: _____

HOW WOULD YOU RATE YOUR DIET? (Circle one) Poor Fair Good Needs Improvement

HOW WOULD YOUR RATE YOUR EXERCISE/ACTIVITY LEVEL? (Circle one) Daily Weekly Monthly None

Would you like to discuss diet and/or exercise options with the Doctor? (circle one) YES NO

Put a # in each space as to how much you use or consume in a WEEK. (i.e. 5 sodas, or 12 packets of sweeteners PER WEEK)

__ Coffee __ Tea __ Soda __ Artificial Sweeteners __ Alcohol __ Recreational Drugs __ Packs of cigarettes

ACCIDENTS and TRAUMA HISTORY

BROKEN BONES: **1** (What) _____ (When/Date) _____ **2** (What) _____ (When/Date) _____

SURGERIES: **1** (What) _____ (When/Date) _____ **2** (What) _____ (When/Date) _____

X-RAYS or MRI: **1** (What) _____ (When/Date) _____ **2** (What) _____ (When/Date) _____

MISC TRAUMAS/INJURIES: Knocked Unconscious; Dislocations; Concussion; Head Injuries; Extensive Dental Work; Spinal Tap...etc

1. _____

2. _____

3. _____

FAMILY HEALTH PROFILE

Family health patterns often emerge and may lead to illness and health conditions within individual family members. Please describe any health related issues such as cancers, chronic diseases, illnesses etc.

PARENTS: _____

SPOUSE: _____

SIBLINGS: _____

CHILDREN: _____

YOUR HEALTH HISTORY

*If you have ever suffered from any of the following, please ✓ all that apply.
If it is something you are experiencing now, please mark with a "C" for current.*

GENERAL:

- Depression Dizziness Fainting Fatigue Loss of sleep Confusion Heel Lifts/Shoe Inserts
 Convulsions/Seizures Jaw Pain Painful Tailbone Shoulder Pain Neck Pain
 Hand Pain/tingling Leg Pain/tingling Arm/Back Pain/tingling Low Back Pain
 Large Amounts of Weight Loss/Gain : How much _____ When _____
 Numbness in Hands Feet Both Disc Problems (bulging or herniated)

DISEASES/CONDITIONS:

- Appendicitis Anemia Arthritis Alcoholism Abdominal Surgery
 Abnormal Bleeding/Clotting Cancer High cholesterol Diabetes Epilepsy
 Headaches Hernia Migraines Mental Illness Measles Mumps Prosthesis
 Pleurisy Pneumonia Polio Skin Problems Abnormal Spinal Curves/Scoliosis

CARDIOVASCULAR/RESPIRATORY:

- Abnormal Blood Pressure Cold Extremities Stroke TIA Difficulty Breathing Pace Maker
 Irregular Heartbeat Swollen Ankles Varicose Veins Chest Pain Lung Problems
 Heart Disease Bronchitis Emphysema Whooping Cough Chronic Cough

GASTRO-INTESTINAL:

- Gas/Bloating after meals Colon Problems Constipation Diarrhea Hemorrhoids
 Liver Problems Nausea Eating Disorder Vomiting Vomiting Blood Ulcers
 Poor Appetite Poor Digestion Heartburn Irritable Bowel Colitis Bloody Stool

GENITO-URINARY:

- Excessive/Frequent urination Pain with urination Bedwetting
 Bladder Problems Prostate Problems Kidney Infections/Kidney Stones
 Excessive Thirst Cramps Painful periods/Irregular cycle Miscarriage

EYES/EARS/NOSE/THROAT:

- Asthma Sinus Problems Sore Throats Blurred Vision Other Vision Problems
 Ear Pain Hearing Loss/Difficulty Hearing Ringing in Ear Nose Bleeds
 Thyroid HYPO or HYPER Goiter Allergies _____

If you have ever been diagnosed with any other disease or condition, please describe:
