COMPLETE HEALTH

Date: ____/____/_____

PATIENT INFORMATION

First Name:_____

Last Name:_____

Date of Birth ____/____/_____ Sex: M____ F____

Address:_____Apt. #_____

City:_____ State:_____ Zip:_____

Email:_____

Employer:_____

Address:_____

City:_____ State:_____ Zip:_____

Marital Status: Single____ Married____ Other____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Is it ok to call you at work?: ____ Yes ____No

EMERGENCY CONTACT:_____

Relationship:_____ Phone:_____

How did you hear about us?

___Spouse is a patient Name:_____

___Referred by: _____

___Internet ___Insurance Co. ___Physician

DEMOGRAPHICS

Employment Status: ___Employed ___FT Student ___PT Student ___Retired ___Self Employed ___Other

Race: ___White ___Black/African American ___Hispanic ___Asian Indian
___Asian ___American Indian/Alaskan Native ___Chinese ___Vietnamese
___Japanese ___Native Hawaiian/Pacific Island ___Korean ___Filipino
___Samoan ___Guamanian/Chamorro ___I choose not to specify ___Other:_____

Multi-Racial: ___Yes ___No ___Unknown

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___I choose not to specify

Preferred Language: ___English ___Spanish ___Chinese ___German ___American Sign Language
___French ___Tagalog ___Italian ___Japanese ___Polish ___French Creole
___Koren ___Arabic ___Russian ___Armenian ___Greek ___Portuguese
___Hindi ___Persian ___Gujarati ___Vietnamese ___Urdu ___I choose not to specify

VERIFICATION QUESTION

(For access to your electronic health records)

___What is the name of your favorite pet? ___In what city were you born? ___What high school did you attend?
___What was the make of your first car? ___What is your favorite movie? ___On what street did you grow up?
___What is your mother's maiden name? ___When is your anniversary?

Answer to the chosen question:_____

ACCIDENT INFORMATION

Is your condition due to an accident? ___Yes ___No Date of Accident: ____/____/_____

Type of Accident: ___Auto ___Work ___Home ___Other

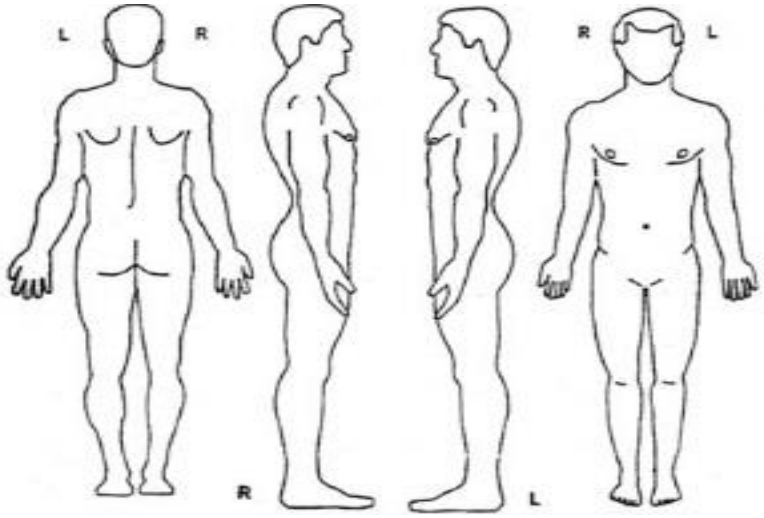
To whom have you made a report of your accident?

___Auto Insurance ___Employer ___Workers Comp. ___Other

SYMPTOM INFORMATION

By using the key below, please indicate on the body diagram where you are experiencing the following symptoms:

# = Numbness
X = Burning
/ = Stabbing
0 = Pins & Needles
+ = Dull Ache



Describe your symptoms:_____

_____

When did your symptoms start? ____/____/_____

How did your symptoms begin?_____

_____

1. Frequency of symptoms: ___Constantly ___Frequently ___Occasionally ___Intermittently

2. Type of pain: ___Sharp ___Dull ache ___Numb ___Shooting ___Burning ___Tingling ___Stabbing

3. Changes in pain? ___Getting better ___Not changing ___Getting worse

4. Over 4 weeks, indicate the average intensity of your symptoms:
___0 None ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 Unbearable

5. Over 4 weeks, has pain interfered with your normal work/housework?
___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

6. Over 4 weeks, has pain interfered with your social activities?
___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time

7. Your overall health right now is: ___Excellent ___Very good ___Good ___Fair ___Poor

8. Other doctors? ___None ___Other Chiropractor ___Medical Doctor ___Physical Therapist ___Other

9. Other treatment types? ___Adjustments ___Physical Therapy ___Medication ___Surgery ___Other

10. When was this treatment? ___In the last month ___2-3 months ___3-6 months ___6 months - 1year
___1-2 years ___2-5 years ___5-10 years

11. Imaging: ___X-rays ___MRI ___CT Scan ___Other

12. When was the imaging? ___In the last month ___2-3 months ___3-6 months ___6 months - 1year
___1-2 years ___2-5 years ___5-10 years

13. Similar symptoms in the past? ___Yes ___No

14. Previous treatment? ___This office ___Other Chiro. ___Medical Doctor ___Physical Therapist ___Other

15. Occupation: ___Professional/Executive ___White Collar/Secretarial ___Tradesperson ___Laborer
___Homemaker ___Student ___Retired ___Other

16. If you are not retired, a home maker, or a student, what is your work status?
___Full-time ___Part-time ___Self-employed ___Unemployed ___Off Work ___Other

CURRENT HEALTH

Family Physician:_____

Telephone: (_____) _____ - _____

Fax: (_____) _____ - _____

Allergies: ___Latex ___Adhesive

___Other:_____

Are you Pregnant? Yes____ No____

Due Date: ____/____/_____

HEALTH HISTORY

Please describe any injuries/surgeries you have had:

Falls:_____ Date:_____

Head Injuries:_____ Date:_____

Broken Bones:_____ Date:_____

Dislocations:_____ Date:_____

Surgeries:_____ Date:_____

FAMILY HISTORY

Has anyone in your family ever had any of the following? Please specify (parents and siblings only):

Arthritis	___Yes	___No	Relation:_____
Cancer	___Yes	___No	Relation:_____
Cholesterol Problems	___Yes	___No	Relation:_____
Diabetes	___Yes	___No	Relation:_____
Heart Problems	___Yes	___No	Relation:_____
High Blood Pressure	___Yes	___No	Relation:_____
Stroke	___Yes	___No	Relation:_____
Thyroid Problems	___Yes	___No	Relation:_____

Do you have any children? ___No

___Male under 6 years ___Male under 10 years ___Male under 19 years ___Male over 19 years

___Female under 6 years ___Female under 10 years ___Female under 19 years ___Female over 19 years

SOCIAL HISTORY

Caffeine Use:	___Never	___Occasionally	___Often	Amphetamine Use:	___Past	___Present
Drink Alcohol:	___Never	___Occasionally	___Often	Barbiturate Use:	___Past	___Present
Chew Tobacco:	___Never	___Occasionally	___Often	Cocaine Use:	___Past	___Present
Experience Stress:	___Never	___Occasionally	___Often	Crystal Meth Use:	___Past	___Present
Exercise:	___Never	___Occasionally	___Often	Heroin Use:	___Past	___Present
Wear Seat Belt:	___Never	___Usually	___Always	Marijuana Use:	___Past	___Present

Smoke:___1 pack or less a day ___1 pack or more a day

ACTIVITIES

Occupational:_____ Manual Labor: __Light __Medium __Heavy

Recreational: _____

REVIEW OF SYMPTOMS

Have you had trouble with any of the following:

Cardiovascular: ___No

	Present	Past
Poor Circulation		
High Blood Pressure		
Aortic Aneurism		
Heart Disease		
Vascular Disease		
Heart Attack		
Chest Pain		
High Cholesterol		
Pace Maker		
Jaw Pain		
Irregular Heartbeat		
Swelling in Legs		

Genitourinary: ___No

	Present	Past
Kidney Disease		
Lower Side Pain		
Burning Urination		
Frequent Urination		
Blood in Urine		
Kidney Stone		

Hematologic/ Lymphatic: ___No

	Present	Past
Hepatitis		
Blood Clots		
Cancer		
Easy Bruising		
Easy Bleeding		
Fevers/Chills/Sweats		

Respiratory: ___No

	Present	Past
Asthma		
Tuberculosis		
Shortness of Breath		
Emphysema		
Cold/Flu		
Cough/Wheezing		

Ears/Nose/Throat: ___No

	Present	Past
Dizziness		
Hearing Loss		
Sinus Infection		
Nosebleed		
Sore Throat		
Difficulty Swallowing		
Bleeding Gums		

Eyes: ___No

	Present	Past
Glaucoma		
Double Vision		
Blurred Vision		

Integumentary: ___No

	Present	Past
Skin Lesions		
Skin Ulcers		
Skin Disease		
Eczema		
Psoriasis		
Rashes		

Allergic/ Immunologic: ___No

	Present	Past
Hives		
Immune Disorder		
HIV/AIDS		
Allergy Shots		
Cortisone Use		

Gastrointestinal: ___No

	Present	Past
Gallbladder Problems		
Bowel Problems		
Constipation		
Liver Problems		
Ulcers		
Diarrhea		
Nausea/Vomiting		
Bloody Stools		
Poor Appetite		

Musculoskeletal: ___No

	Present	Past
Gout		
Arthritis		
Joint Stiffness		
Muscle Weakness		
Osteoporosis		
Broken Bones		
Joints Replaced		

Endocrine: ___No

	Present	Past
Thyroid Disease		
Diabetes		
Hair Loss		
Menopausal		
Menstrual Problems		

Psychiatric: ___No

	Present	Past
Depression		
Anxiety Disorder		
Unusual Stress		

Constitutional: ___No

	Present	Past
Weight Loss/Gain		
Energy Level Problem		
Difficulty Sleeping		

Neurologic: ___No

	Present	Past
Babinski		
Stroke		
Seizures		
Head Injury		
Dementia		
Brain Aneurysm		
Numbness		
Severe Headaches		
Pinched Nerves		
Parkinsons's Disease		
Carpal Tunnel		
Spinning Balance		

MEDICATIONS

Please list current medications, dosage, and frequency. ___None

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1._____			5._____		
2._____			6._____		
3._____			7._____		
4._____			8._____		

Please list any known allergies to medications. ___None

1._____ 3._____

2._____ 4._____

SMOKING

Do you smoke tobacco of any kind? ___Yes, currently ___Former smoker ___Never been a smoker

If yes, how often do you smoke? ___Everyday ___Sometimes

If yes, what is your level of interest in quitting smoking?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

CURRENT HEALTH CONDITIONS

Has any doctor diagnosed you with Hypertension presently? ___Yes ___No

If yes, please describe:_____

Has any doctor diagnosed you with Diabetes presently? ___Yes ___No What kind? ___Type 1 ___Type II

If yes, was your blood lab-work test for hemoglobin A1c>9.0%? ___Yes ___No ___Not sure

If yes, other comments regarding Diabetes:_____

Briefly list any other main health problems:_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ___Yes ___No

TO BE PERFORMED BY CLINIC STAFF

Height: _____ inches

Weight:_____pounds

BP: _____/_____