BEST CHIROPRACTIC HEALTH CENTER

STEP 1

PERSONAL HISTORY

NAME: DATE: / /
ADDRESS:
CITY STATE: ZIP:
HOME PHONE #: CELL #:
WORK #:
SOCIAL SECURITY #:
BIRTH DATE: / / AGE: SEX: M F
HEIGHT: WEIGHT:
MARITAL STATUS: SINGLE MARRIED SPOUSE'S NAME:
DRIVERS LICENSE #: EXP DATE: STATE:
EMAIL:

In case of an emergency, who should we contact?

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Work Phone: ______________________

CONSENT TO CARE FOR A MINOR CHILD

I hereby authorize **Head, Hands and Heart Chiropractic and Wellness** to administer healthcare services as they deem necessary to my children.

Signature ______________________

FEMALE PATIENTS ONLY

I declare that to the best of my knowledge I am not pregnant and I submit to spinal x-ray analysis for diagnosis of my condition. I will hold **Head, Hands and Heart Chiropractic and Wellness** harmless if I fail to report this information.

Signature ______________________

FINANCIAL RESPONSIBILITY

I am solely responsible for any changes or fees associated with my health care services, and I will be advised of all changes prior to execution of any services.

Signature ______________________

PLEASE GIVE THE RECEPTIONIST A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARE (if insured) SO COPIES CAN BE MADE FOR YOUR FILE.

BEST CHIROPRACTIC HEALTH CENTER

STEP 2

In order for us to better serve you, please provide detailed answers to the questions below

1.) In your own words, what is the primary reason for coming to our office. (in detail)

____

____

2.) Please describe the location and sensations of your symptoms (in detail) (examples: Weakness, Tingling, Numbness, Pins and Needles, Burning, Aching, Stabbing, Shooting)

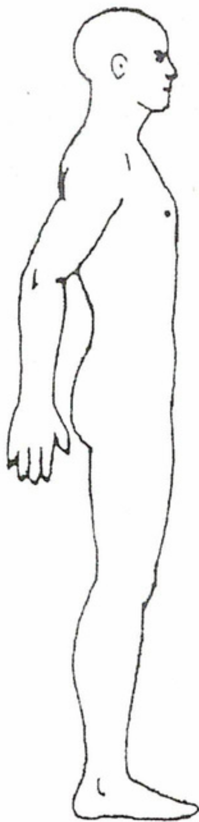
____

____

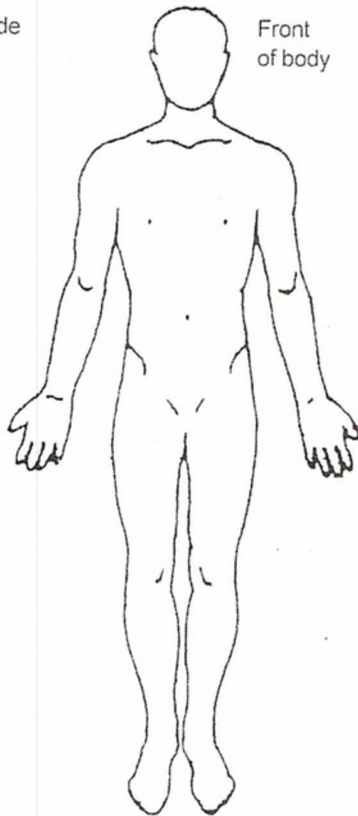
3.) Please mark the area(s) of injury or discomfort on the illustration below using the appropriate symbols.

Description →	Weakness	Tingling	Numbness	Pins & Needles	Burning	Aching	Stabbing	Shooting
Use Symbol →	W	T	N	P	B	A	ST	SH

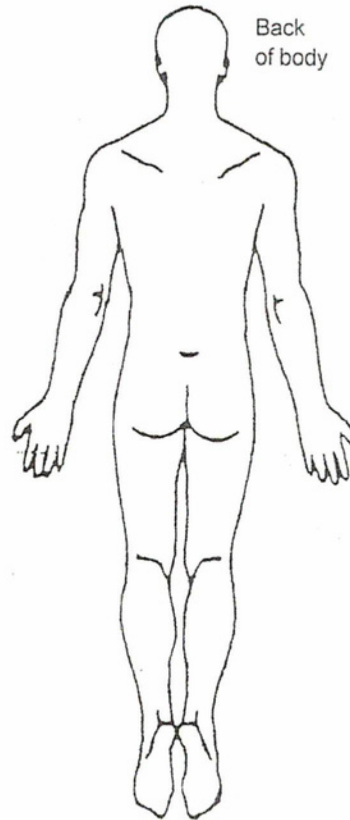
Draw a circle ◯ around any area of pain not represented by a symbol.



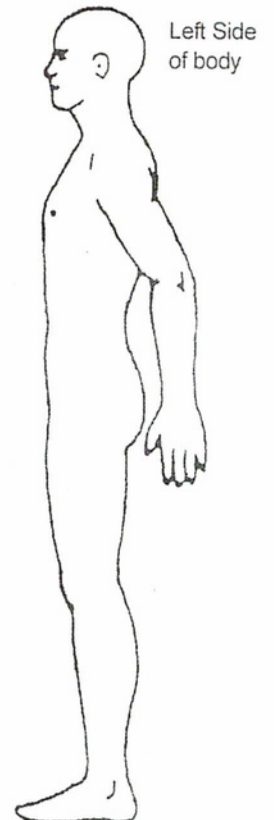
Right Side of body



Front of body



Back of body



Left Side of body

4.) On a scale from 0 to 10, grade the severity of each of the above symptoms separately. ("0" being no discomfort and "10" being extreme discomfort)

____

5.) When did you first begin to notice the symptoms?

____

6.) Have you ever had these symptoms before? (When? How often?)

____

BEST CHIROPRACTIC HEALTH CENTER

STEP 3

Please use the space provided to explain in detail any information to clarify any of the checked off conditions below.

Have You or any Family member had any of the following: (S for Self or F for family member)

__ Bone Fractures of any Kind
__ Arthritis
__ Skin or Rash problems
__ Colds & Flu Shots
__ Seasonal Allergies or Allergic Reactions
__ Sinus or Ear Infection
__ Menstrual cramps
__ Pre-Menstrual Syndrome
__ Hysterectomy
__ Hormone Imbalances
__ Hormone Replacement Therapy
__ Thyroid Condition
__ Enlarged Prostate
__ Impotence or loss of libido
__ Stomach Acid reflux or Esophageal Reflux
__ Dizziness, Lightheadedness or Vertigo
_ Digestion Problems
_ Bleeding Ulcers or Bleeding Gastritis
_ Urine or Stool Incontinence
_ Diarrhea or Constipation
_ Headaches (Tension, Stress. Hormonal)
_ Neck pain or stiffness
_ Numbness, Pain or Tingling in the shoulder,
_ arms, elbows, hands, or Fingers
_ Numbness, Pain, or tingling in the buttocks,
_ thighs, knees, legs, feet, toes
_ Coldness or Heat found in the Hands or Feet
_ Jaw pain (TMJ)
_ Mid back Pain or Stiffness
_ Low back Pain or Stiffness

__ Blood in Urine or Stool
__ Chest Pain
__ Heart conditions of Any Kind
__ Emphysema or Asthma (circle one)
__ Congestion or Pneumonia
__ Cancer of Any Kind
__ Diabetes type 1 or 2 (circle one)
__ Seizures, epilepsy
__ Stroke
__ High/low blood pressure
__ Liver conditions
__ Gall bladder conditions
__ Kidney conditions
__ Pregnancy (Prior)
__ AIDS. HIV
__ Depression
_ Anxiety
_ ADD / ADHD
_ Coughing, Sneezing, or Bowel Movements (with Pain)
_ Daily Fatigue
_ Blood Disorders
_ General Muscle Aches or pains
_ Appendicitis
_ Unexplained Weight Loss or Gain
_ Loss of smell or taste
_ Ringinq in Ears Right Left
_ Loss of Hearing Right Left
_ Loss of vision, blurred Right Left
_ Doubled vision Right Left
_ Hip joint pain or replacement Right Left
_

Physicians Notes

BEST CHIROPRACTIC HEALTH CENTER

STEP 4

In order for us to better serve you, please provide detailed answers to the questions below.

1.) Are the symptoms becoming more frequent? Yes No If "Yes", please explain.

____

____

2.) Are the symptoms becoming more severe? Yes No If "Yes", please explain.

____

____

3.) What activities make your symptoms worse. (e.g. lifting, bending, standing, walking etc.)

____

____

4.) What activities make your symptoms better.

____

____

5.) What time of day do your symptoms appear worse? Please describe. (e.g. morning, afternoon, evening)

____

____

6.) Have you been treated by other Doctors for these symptoms? Yes No

Dr. Name: ______________________ date ____/____/____

TESTS __Blood Test __X-Ray / MRI __ Lab Work __other ______________

TREATMENT __ Medications __Physical Therapies __ other ______________

Results of treatment: ______________________

Length of time under care: ______________________

7.) What types of Medications are you taking at this time?

____

____

8.) Do you take over-the-counter drugs? Yes No If "Yes", what do you usually take?

______________________ ______________________

______________________ ______________________

BEST CHIROPRACTIC HEALTH CENTER

STEP 5

In order for us to better serve you, please provide detailed answers to the questions below.

1.) How does your major complaint affect you at **work** (when severe)?

____
____
____
____
____
____
____
____

2.) How does your major complaint affect you at **home** (when severe)?

____
____
____
____
____
____
____
____

3.) How does your major complaint affect you at **recreationally** (when severe)?

____
____
____
____
____
____
____
____