CONFIDENTIAL HISTORY & CONSULTATION

Case#_____

No patient will be seen by the Doctor without this form completely filled out

Date_____/_____/_____

First Name_____ Middle_____ Last_____ SSN _____-____-_____

Address _____ City _____ State_____ Zip _____

Date of Birth _____/_____/_____ Age _____ Sex M F Height _____'_____" Weight _____ lb's

Check Preferred Contact Phone Number : ❑ Home (_____) _____-_____ ❑ Cell (_____) _____-_____

❑ Work (_____) _____-_____ EXT _____ E-mail address _____

Name of Employer _____ Position/Type of Work _____

Ethnicity *(Check all that apply):* ❑ American Indian/Alaska Native ❑ Asian ❑ African American ❑ Hispanic/Latino

❑ Native Hawaiin/Pacific Islander ❑ White ❑ Prefer no answer ❑ Other: _____

Primary Language: ❑ English ❑ Español ❑ Français ❑ Other: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Number of Children: _____

Name of Spouse _____ Date of Birth _____/_____/_____ Contact # (_____) _____-_____

Spouses Employer _____ Position/Type of Work _____

EMERGENCY CONTACT INFORMATION:

Name _____ Phone (_____) _____-_____ Relation _____

PAST HEALTH HISTORY:

Please include dates of surgeries, if approximate please put a "**?**" next to it.

Appendectomy _____/_____ Hysterectomy _____/_____ Spinal _____/_____ Gallbladder _____/_____ Tonsillectomy _____/_____

Other: _____

Fill the box of the following conditions YOU have had. Mark an "X" for the following conditions your Parents/Siblings have had.

❑ Alcholism	❑ Stroke	❑ Gout	❑ Allergies
❑ Migraine Headaches	❑ Arthritis	❑ AIDS	❑ Rheumatic Fever
❑ Fibromyalgia❑	❑ Diabetes	❑ Miscarriage	❑ Scarlet Fever
❑ Appendicitis	❑ Cold Sores	❑ Polio	❑ Emphysema
❑ Heart Attack	❑ Pneumonia	❑ Measles	❑ Sinus Trouble
❑ Arteriosclerosis	❑ Ulcers	❑ Chorea	❑ Whooping Cough
❑ Venereal Disease	❑ Back Pain	❑ Goiter	❑ Typhoid Fever
❑ Tuberculosis	❑ Malaria	❑ Anemia	❑ Multiple Sclerosis
❑ Diptheria	❑ Cancer	❑ Mumps	
❑ Eczema	❑ Epilepsy	❑ Pleurisy	

Allergies: _____

Current Medications: _____

List any vitamins you take on a regular basis: _____

Past fractures, dislocations, or broken bones?: _____

Past accidents or falls?: _____

How many hours do you sleep per night?:_____ Does pain disrupt your sleep? ❑ Yes ❑ No ❑ Sometimes

Do you use sleeping aids? ❑ Yes ❑ No if yes, what?:_____ Is your sleep restful? ❑ Yes ❑ No ❑ Sometimes

Check what applies best to you:

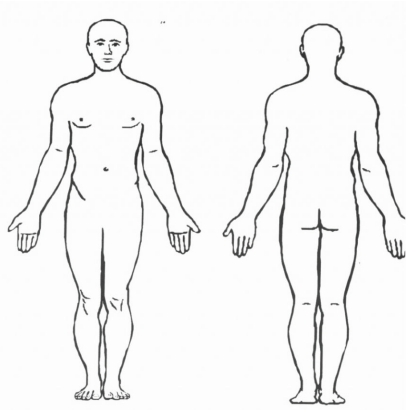
Date of Last	<6 Months	6-18 Months	>18 Months	Never
Spinal Exam	❑	❑	❑	❑
Spinal Adjustment	❑	❑	❑	❑
Blood Test	❑	❑	❑	❑
Urine Test	❑	❑	❑	❑
X-Ray	❑	❑	❑	❑

Please turn over complete the back side of this page.

Name:_____Case#:_____

Habits	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Pop	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

Mark an X on the location of your pain



What is/are your major compaint(s)?:_____

How did this start? (Date/Time if applicable)_____

Pain is: ❑ Constant 75-100% of the day ❑ Frequently 50-75% ❑ Occasionally 25-50% ❑ Intermittenly 0-25%

❑ Sharp ❑ Dull ❑ Shooting ❑ Numb ❑ Tingling ❑ Throbbing

Have you had pain in your ❑ Arms ❑ Hands ❑ Fingers ❑ Legs ❑ Feet ❑ Toes **On the** ❑ Left ❑ Right ❑ Both

Is this due to an auto accident? ❑ Yes ❑ No Were you on the clock at the time? ❑ Yes ❑ No

if yes to auto, did you lose consciousness / blurred vision / feel dazed? ❑ Yes ❑ No

Were you wearing a seatbelt? ❑ Yes ❑ No Did you hit anything during the accident? ❑ Yes ❑ No

Do you have pain while coughing / sneezing / taking a deep breath? ❑ Yes ❑ No

Have you noticed a recent change in bladder or bowel functions? ❑ Yes ❑ No

Have you noticed any abnormal discharges? ❑ Yes ❑ No

Have you had a similar condition in the past? ❑ Yes ❑ No When?:_____

What aggravates your condition?_____

What helps your condition?_____

Have you tried: ❑ Ice ❑ Heat ❑ Over the counter painkillers ❑ Prescripton pain killers ❑ Rest

Is this current pain disturbing your: ❑ Sleep ❑ Work ❑ Social Life ❑ Mood ❑ Daily Functions

Have you ever been treated by a Doctor of Chiropractic? ❑ Yes ❑ No Who?: Dr. _____

When approximately?:_____ What areas did they treat?: ❑ Neck ❑ Mid-Back ❑ Lower ❑ Other

Since x-rays can be harmful to unborn children, please check this box ❑ if you suspect you may be pregnant.

Please check all types of coverage that apply:

❑ Personal Insurance ❑ Cash ❑ Medicare ❑ Workers Compensation ❑ Auto Insurance ❑ Group Policy

We may use and disclose information about you to carry out treatment, payment, and healthcare operations. You have the right to ask that we restrict how protected information about you is used or disclosed. You have the right to revoke this agreement in writing, except to the extent that we have taken action in reliance on your consent. By signing this form, you consent to our use and disclosure of protected health information about you regarding your treatment, payment, and healthcare options. By signing this you allow us to use such information in the normal office protocol of performing treatment, payment and healthcare operations.

PLEASE SIGN BELOW STATING YOU UNDERSTAND THE ABOVE STATEMENT

X: _____ Date:_____

The below signature gives consent for the Doctor to treat you. You <u>WILL NOT</u> be treated without signing below.

X: _____ Date:_____

The below signature states that you give consent as a parent or legal guardian to treat the aforementioned minor

X: _____ Date:_____

Parent / Legal Guardians Printed Name:_____