CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____ DOB: _____ SSN#: _____
First, Middle, Last

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ E-mail Address:_____

Sex: ☐M ☐F Employer Name & Address: _____ _____

Type of Work: _____Who May We Thank for Referring You? _____

Please Check One: ☐ Student ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Birthdate: _____ Spouse's SS#: _____

Child's Names: _____ Age: _____ Birthdate: _____

Child's Names: _____ Age: _____ Birthdate: _____

Child's Names: _____ Age: _____ Birthdate: _____

Who is Responsible for Your Bill, You and: ☐ Health Insurance ☐Medicare ☐Self ☐Auto Ins. ☐Work/Comp

Our Advertisements You Have Seen: ☐Yellow Pages ☐TV ☐Radio ☐Health Talk ☐Screening ☐News Paper ☐Mailout

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RESPONSIBLE PARTY INFORMATION (This section MUST be completed if patient is a minor)

Name: _____ DOB: _____ SSN#: _____
First, Middle, Last

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Insured: _____ Relationship to Patient: _____ SS#: _____ DOB: _____

Insured's Employer: _____ Ins. Phone: ( )_____

Insurance Co: _____ Policy #: _____

Street Address: _____ City: _____ State: _____Zip: _____

SECONDARY INSURANCE INFORMATION

Insured: _____ Relationship to Patient: _____ SS#: _____ DOB: _____

Insured's Employer: _____ Ins. Phone: ( )_____

Insurance Co: _____ Policy #: _____

Street Address: _____ City: _____ State: _____Zip: _____

In Case of an Emergency, please give the name of a relative or friend not living with you.

Name: _____ Relationship to Patient: _____ Home Phone: ( )_____

Address: _____ Work Phone: ( ) _____

City: _____ State: _____ Zip: _____

CURRENT HEALTH CONDITION

Please List Your Chief Health Complaints, Symptoms, or Concerns in the Order of their Severity Below:

1. _____ How Long: _____
2. _____ How Long: _____
3. _____ How Long: _____

What is the Main Reason for Your Appointment Today: _____

- Is Your Condition Due To a(an): A) Auto Accident B) Work Injury C) Gradual Onset D) Unknown E) Other Accident
- Date of Accident/Injury____/____/____ PleaseDescribe:_____
- Were You Disabled From Work? ☐Yes ☐No If Yes, Please List Dates: ____/____/____ to ____/____/____
- Date Symptoms Appeared: _____ Are Your Symptoms: A) Improving B) Getting Worse C) About the same

Circle the Activities That Aggravate Your Condition: A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

Have You Had These Symptoms Before? ☐Yes ☐No If yes, when? _____

Have You Seen Another Dr. for This Condition? A) MD B) Chiropractor C) Osteopath D) Acupuncturist E) Dentist F) Therapist

- Dr.'sName:_____DateConsulted____/____/_____Diagnosis_____

Medications You Presently Take: ☐Pain Killers ☐ Muscle Relaxers ☐Anti-Inflammatory ☐Blood Pressure Pills ☐Insulin ☐Anti-Depressants ☐Sleeping Pills ☐Aspirin/Similar ☐Digestive Aids ☐Diet Pills Others: _____

Does Anyone Else in Your Family Have the Same or Similar Condition: ☐Yes ☐No Who: _____

Have You Been Treated For Any Health Condition in the Last Year? ☐Yes ☐No If Yes, Please Explain: _____

_____

Major Accidents, Injuries, or Falls You Have Had in Your Lifetime: _____

DAILY LIFESTYLE & HABITS: Please Fill Chart Below Out Completely.

Alcohol	Daily	2 / week	2 / month	None
Coffee	>5 cups	2-4 cups	1 cup	None
Tobacco	>2 packs	1 pack	<1/2 pk	None
Drugs	Daily	1 / week	1 / month	None
Exercise	Daily	3 / week	1 / week	None
Sleep	>10 hrs	7-10 hrs	4-7 hrs	<4 hrs
Appetite	Heavy	Moderate	Light	None

Do you wear: ☐Heal lifts ☐Foot Pads ☐Innersoles ☐Arch Supports

FEMALES ONLY:
When was the First Day of your last Cycle?
_____

ARE YOU PREGNANT?
☐Yes ☐No ☐Maybe
PLEASE INITIAL BELOW:

_____

Major Surgery or Operations You Have Had: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Heart ☐ Low Back ☐ Neck ☐ Knee ☐ Female ☐ Other: _____ Please Give Dates: _____

PAST HEALTH HISTORY

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of Your Care.

PLEASE CHECK ANY OF THE FOLLOWING DISEASES OR CONDITIONS YOU HAVE HAD:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Anemia	☐ Eczema
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Auto Immune Disease	☐ Measles
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Heart Disease	☐ Lumbago
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Thyroid	☐ Asthma
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder	☐ HIV Positive	☐ Kidney Stones

PLEASE CHECK THE BOX OF SYMPTOMS YOU HAVE HAD IN THE <u>PAST 6 MONTHS</u>: ☒

THEN CIRCLE THE SYMPTOMS YOU ARE EXPERIENCING AT THE <u>PRESENT TIME</u>:

☐Headaches

MUSCULO-SKELETAL SYSTEM
- ☐ Head Pain / Problems
- ☐ Neck Pain / Problems
- ☐ Shoulder Pain / Problems
- ☐ Arm Pain / Problems
- ☐ Hand Pain / Problems
- ☐ Mid Back Pain / Problems
- ☐ Chest Pain / Problems
- ☐ Stomach Pain / Problems
- ☐ Low Back Pain / Problems
- ☐ Hip Pain / Problems
- ☐ Leg Pain / Problems
- ☐ Foot Pain / Problems
- ☐ Walking Pain / Problems
- ☐ Chewing / Jaw Pain / Problems
- ☐ General Stiffness

NERVOUS SYSTEM
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Muscle Cramping
- ☐ Stress

GENERAL SYSTEM
- ☐ Fatigue
- ☐ Allergies
- ☐ Fever
- ☐ Headaches
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Sinus Headaches
- ☐ Loss of Sleep

GENITO-URINARY SYSTEM
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine
- ☐ Bed-wetting

GASTRO-ENTESTINAL SYSTEM
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas / Bloating After Meals
- ☐ Heartburn / Indigestion
- ☐ Black / Bloody Stool
- ☐ Colitis

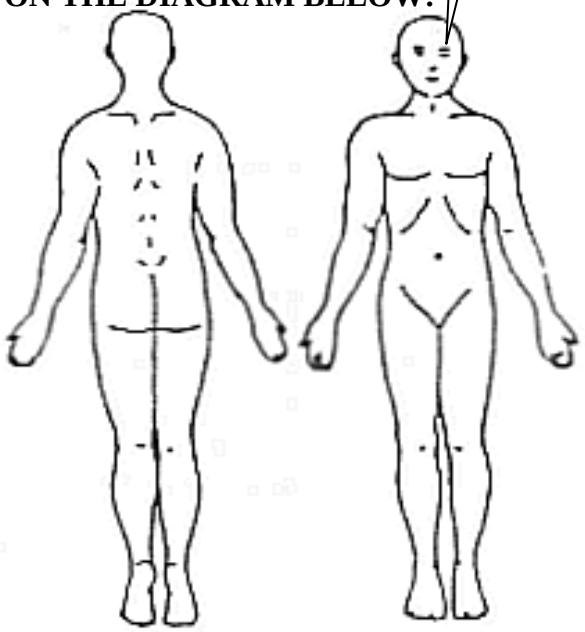
EARS, EYES, NOSE & THROAT
- ☐ Sinus Problems
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Ringing in Ears
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

CARDIO-VASCULAR-RESPIRATORY
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Please do not forget to Draw your pain on me!!!

DARKEN IN THE AREA OF YOUR PAIN OR DISCOMFORT ON THE DIAGRAM BELOW!



PLEASE READ: I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the this Clinic will be credited to my account upon receipt. **<u>However</u>**, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment of these services in full. I also understand that if I suspend or terminate my care in this office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I also agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion and it is placed in collections.

<u>PAST DUE BALANCES WILL INCUR AN INTEREST CHARGE OF 1% EACH BILLING CYCLE.</u>

Patient's Signature: _____ Date: _____

Parent or Guardian's Signature Authorizing Care: _____ Date: _____

OUR PURPOSE AT THIS CLINIC ISTO SUPPORT AS MANY FAMILIES AS POSSIBLE IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND HOW THEIR BODIES FUNCTION AND IN TURN GO OUT AND EDUCATE OTHERS.