

Date: \_\_\_\_\_

|                      |
|----------------------|
| Office use only      |
| 1) Patient No: _____ |
| 2) Type Case: _____  |

## CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City: \_\_\_\_\_ Mobile/Cell/Beeper: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please Check One:  Student  Single  Married  Divorced  Separated  Widowed

Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Your SSN#: \_\_\_\_\_ Who May We Thank For Referring You? \_\_\_\_\_

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  Medicaid  Auto Ins.  Work/Comp

Method of Payment For Today's Services:  Cash  Check  Master Card  Visa  Discover  Other

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

## 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: \_\_\_\_\_

9. Is Your Condition Due To a(an): A) Auto Accident B) Work Injury C) Gradual Onset ) Unknown E) Other Accident

Date of Accident or Injury: \_\_\_\_\_ Please Describe: \_\_\_\_\_

Were You Disabled from Work?  Yes  No If yes, Please Give Dates: \_\_\_\_\_

10. Date Symptoms Appeared: \_\_\_\_\_ Are Your Symptoms: A) Improving B) Getting Worse C) About the same D) Intermittent

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

12. Have You Had These Symptoms Before?  Yes  No If yes, when? \_\_\_\_\_

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

Dr.'s Name: \_\_\_\_\_ Date consulted \_\_\_/\_\_\_/\_\_\_ 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: \_\_\_\_\_

14. 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: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**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 effect your overall course of Your Care.

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

- |  |                                      |  |  |  |
|--|--------------------------------------|--|--|--|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Influenza       | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Eczema        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox   | <input type="checkbox"/> Pleurisy        | <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Measles       |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Lumbago       |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Thyroid             | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer      | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Kidney Stones |

**PLEASE CHECK THE BOX OF SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS:**

**THEN CIRCLE THE SYMPTOMS YOU ARE EXPERIENCING AT THE PRESENT TIME:**  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

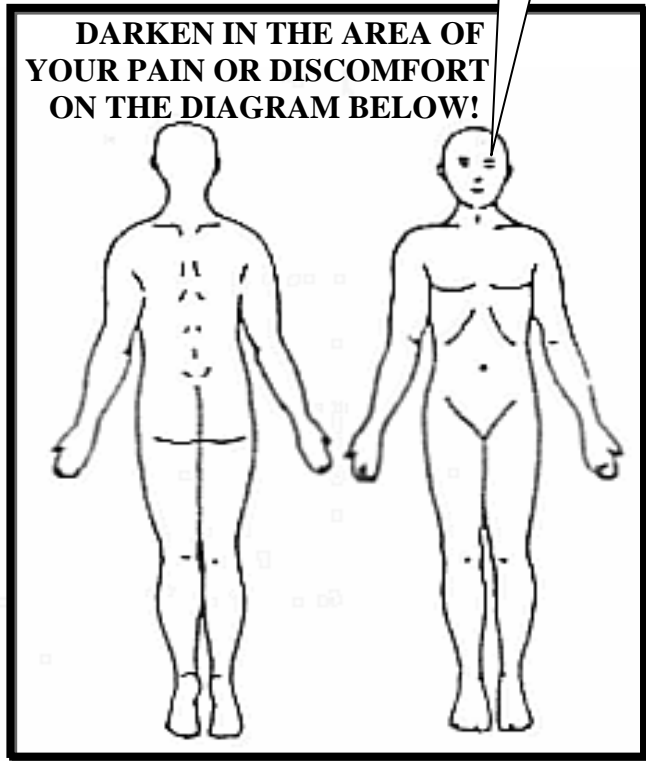
**MALE/FEMALE**

- 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!!!*



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

Reasons for Hospitalizations (Other Than Above): \_\_\_\_\_

**CONFIDENTIAL PERSONAL HEALTH HISTORY**

(CONT. PAGE 3)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

**FEMALES ONLY:**  
 When was the First Day  
 of your last Cycle?  
 \_\_\_\_\_

ARE YOU PREGNANT?  
 Yes  No  Maybe  
 PLEASE INITIAL BELOW:  
 \_\_\_\_\_

Do you wear: Heal lifts Foot Pads Innersoles Arch Supports

DO YOU WANT US TO FILE ON YOUR INSURANCE FOR YOU? YES NO

IF YES, PLEASE FILL OUT INSURANCE INFORMATION BELOW.

INSURANCE INFORMATION: Health Insurance Medicare Medicaid Group Workers Comp Auto Insurance

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Phone: ( ) \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group #: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**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. **However,** 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.

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. 7.09***