CONFIDENTIAL HEALTH HISTORY

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know about you. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you

Name:_____ Date: _____
Address: _____ Phone: _____
_____ DOB: _____
Employer: _____ Occupation: _____
Business Address: _____ Bus. Phone: _____
_____ Cell Phone: _____
Age: ____ Sex: (circle one) M___ F___ Name you prefer to be called:_____
Marital Status: (circle one) S__M__W__ D __ Name of Spouse: _____
Height: _____ Weight: _____ Number of children: ____
Medical Physician: _____ Date of last check-up: _____
Who referred you to our office: _____ Address: _____
_____
Name of person responsible for payment of professional services: _____
Name of insurance company: _____

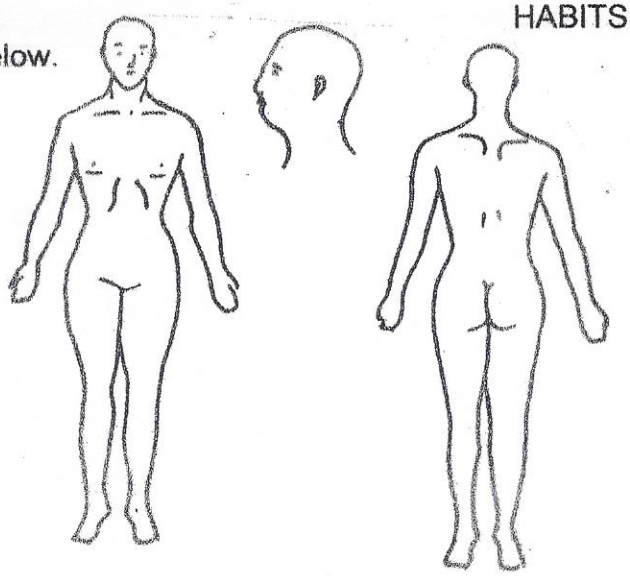
HEALTH REPORT

Is this visit for preventive maintenance? Yes ___ No ___
Please describe the principal health problems for which you came to this office:
_____
When did this condition start? _____
Is your condition getting progressively worse? Yes ___ No ___ Constant ___ Comes & goes_____
Is your condition interfering with your: Work ___Sleep ___ Daily routine ___ Other _____
List any other doctors seen for this: _____
List any diagnosis(es) and type of treatment(s): _____
_____
Have you lost any days of work? Yes ___ No ___ Dates: _____
Is your condition due to an accident? Yes ___ No ___ Date of accident: _____
Have you had similar conditions before? Yes ___ No ___ If yes, explain: _____
_____
List the name of any relatives who have/had similar problem(s): _____
_____
Have you had received chiropractic treatment previously? Yes ___ No ___ if yes, explain _____
_____
Has a physician treated you for any health conditions in the last year? Yes ___ No ___
Medications? _____
What vitamins are you currently taking? _____
_____
How long has it been since you have felt well? _____

If additional space is needed use other side of this form.

_____
Patient Signature

Please mark your areas of pain on the figures below.



HABITS: Amount taken daily

Alcohol _____
Coffee _____
Tobacco _____
Water _____
Exercise _____
Sleep _____
Do you wear glasses?
_____

Allergies: _____
_____
_____

List any accidents: _____ Dates _____
Broken Bones: _____ Dates _____
Serious Falls: _____ Dates _____
Injuries: _____ Dates _____
Additional Information: _____
_____

List any **past** or **present** illnesses or medical problems, e.g., heart, lungs, kidney, etc.

_____
_____
_____
_____

List all surgeries: _____ Dates _____
_____ Dates _____
_____ Dates _____

List X-rays, MRI, and CT Scan taken in the last 10 years

_____ Dates _____
_____ Dates _____
_____ Dates _____
_____ Dates _____
_____ Dates _____

Additional Information: _____
_____
_____
_____

I understand that all treatments, x-rays and laboratory examinations are to be paid for as they are received or definite financial arrangements made in advance.

_____
Patients Signature