Chiropractic Family Health Center

TELL US ABOUT YOU (Please Print Clearly)

Name:		Social Security#:		Date:
Date of Birth:	Age:	Sex: M F	Marital Status M S D W	# of children:
Address:				
City:		State:	Zip:	
Home Phone #:		Cell #:		
E-mail Address:				
Spouse's Name:				
Occupation (Current or Previous)				Retired: Y N
Current or Previous Work	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N
In Case of Emergency Contact Name		Phone Number:		

TELL US ABOUT YOUR PAST HEALTH:

Y	N	← Lower Back Pain	Y	N	← Diabetes (A1C = _____)	Y	N	← High Cholesterol
Y	N	← Leg or Foot Pain/Numbness	Y	N	← Hand Problems	Y	N	← Shingles
Y	N	← Prior Spinal Surgeries	Y	N	← Neuropathy	Y	N	← Cancer - Chemotherapy
Y	N	← Spinal Fractures	Y	N	← Heart Attack	Y	N	← Kidney issues or Dialysis
Y	N	← Spinal Stenosis	Y	N	← Heart Problems	Y	N	← Gout
Y	N	← Spinal Arthritis	Y	N	← High / Low Blood Pressure	Y	N	← Knee/Hip/Foot Surgery
Y	N	← Sciatica	Y	N	← Vascular Leg Problems	Y	N	← Leg Fractures
Y	N	← Neck Pain	Y	N	← Vascular Surgery _____	Y	N	← Joint Replacement
Y	N	← Herniated Disc	Y	N	← Stroke	Y	N	← Plantar Fasciitis

TELL US ABOUT ANY MEDICATIONS YOUR CURRENTLY ARE TAKING OR HAVE PREVIOUSLY TAKEN:

Y	**N**	← LIPITOR (Atorvastatin)	**Y**	**N**	← ZETIA (Ezetimibe)	**Y**	**N**	← CYMBALTA (Duloxetine)
Y	**N**	← CRESTOR (Rosuvastatin)	**Y**	**N**	← HYDROCHLOROTHIAZIDE	**Y**	**N**	← ELAVIL (Amitriptyline)
Y	**N**	← ZOCOR (Simvastatin)	**Y**	**N**	← BLOOD PRESSURE MEDS	**Y**	**N**	← EFFEXOR (Venlafaxine)
Y	**N**	← ALTOCOR (Lovastatin)	**Y**	**N**	← LYRICA (Pregabalin)	**Y**	**N**	← OXYCONTIN (Oxycodone)
Y	**N**	← MEVACOR (Lovastatin)	**Y**	**N**	← NEURONTIN (Gabapentin)	**Y**	**N**	← LIDODERM PATCH
Y	**N**	← LESCOL (Fluvastatin)	**Y**	**N**	← TRILEPTAL (Oxacarbaziine)	**Y**	**N**	← CAPSAICIN (Zostrix)
Y	**N**	← PRAVACHOL (Atorvastatin)	**Y**	**N**	← TOPAMAX (Topiramate)	**Y**	**N**	← OVER THE COUNTER MED

PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:

PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD:

WHEN DID THIS BEGIN:
WHAT MAKES IT BETTER:

WHAT MAKES IT WORSE:							
HOW WOULD YOU DESCRIBE YOUR SYPMTOMS (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping
WHAT ARE YOUR PRIMARY SYMPTOMS							
IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)							
WORK	**SLEEP**	**DAILY ROUTINE**	**CHORES**	**WALKING**	**STANDING**	**SHOPPING**	

How would you describe your pain at its worst in the past week?

No pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Please indicate what you consider to be an acceptable level of pain after completion of the treatment, if you have to accept some pain?

No pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Statin DM Chemo Back

When did it Begin

How are Nights

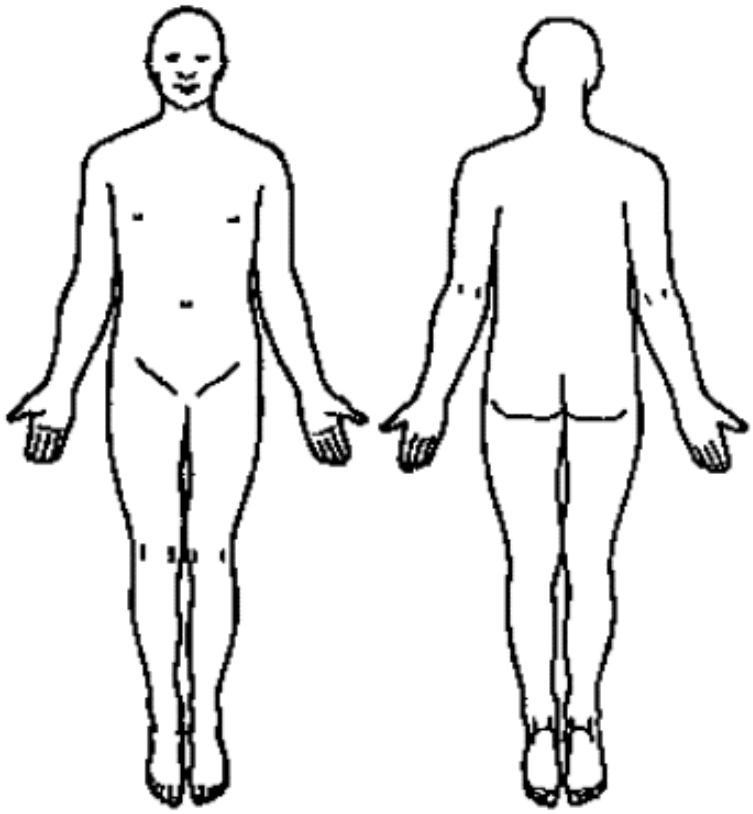
Getting Worse

How's Life Affected by PN

Explain what you feel

When is it worse

Mark the Primary Problem Areas



TELL US ABOUT HOW THIS IS AFFECTING YOU:

What are your symptoms like at their worst:		
Is your **balance** or **walking ability** starting to be affected? ® NO If yes, describe below in what way(s):		
Which of the following is **true** for your condition: (check one of the following)		
____ It's getting better on it's own	____ It's staying the same	____ It's getting worst as time goes by
List any daytime activities (you **used to be able to do** when you were feeling better) that are now limited:		
List any "day-to-day" activities (**OK to do now**) that are getting harder and harder to do:		

A. I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.
B. I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.
C. I understand and agree that health policies are an arrangement between an insurance carrier and myself. Therefore I understand that all future services are charged directly to me and agree to be personally responsible for payment.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature _____ Date _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?