

# Ironton Chiropractic Wellness

## Confidential Patient Health Information

### Personal Information:

Mr.  Mrs.  Miss Name: \_\_\_\_\_ Age: \_\_\_\_\_  M  F  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Drivers License #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_  
Nearest Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
E-mail Address (for Patient Newsletter): \_\_\_\_\_  
HOW WERE YOU REFERRED? \_\_\_\_\_

### Reason for your Visit:

Have you been to this clinic before?  Yes  No  
Purpose of this appointment: \_\_\_\_\_  
Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other  
Please describe the pain and its location: \_\_\_\_\_  
Date of accident/injury, or when condition began: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Is condition getting worse?  Yes  No  stays the same  Comes and goes  
Is this condition interfering with your:  Work  Sleep  Daily Routine  Other  
Have you been treated by another doctor for this condition?  Yes  No  
If yes, please name doctor/health care facility: \_\_\_\_\_

### Insurance Information:

Company Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City/ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insured ID (if different than SS#): \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Policy/Group #: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name of Secondary Insurance Company (if any) \_\_\_\_\_  
Phone Number of Insurance Company \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
If Worker's Compensation or Personal Injury, have you been advised by an attorney? Yes  No   
If yes, attorney's name, address, and telephone number \_\_\_\_\_

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### Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

#### General

C P Allergy  
C P Convulsions  
C P Dizziness  
C P Fainting  
C P Headache  
C P Sudden Weight Loss  
C P Fatigue

#### Muscle & Joint

C P Arthritis  
C P Bursitis  
C P Low Back Pain  
C P Neck Pain/Stiffness  
C P Shoulder Pain  
C P Spinal Curvature  
C P Midback Pain

#### Eyes, Ears Nose & Throat

C P Deafness  
C P Ear-ache  
C P Failing Vision  
C P Nosebleeds  
C P Sinus Infections  
C P Strep Throat  
C P Thyroid Problems

#### Gastrointestinal

C P Colon Probs.  
C P Constipation  
C P Diarrhea  
C P Gall Bladder  
C P Hemorrhoids  
C P Hernia  
C P Liver Probs  
C P Nausea/Vomiting

#### Respiratory

C P Asthma  
C P Chest Pain  
C P Chronic Cough  
C P Spitting up Blood

#### Pain or Numbness in:

C P Shoulders/Arms  
C P Elbows/Hands  
C P Hips/Legs  
C P Ankles/Knees/Feet

#### Skin Problems

C P Bruise Easily  
C P Hives or Allergic Reaction  
C P Skin Rash  
C P Acne

#### Other

C P Alcoholism  
C P Anemia  
C P Cancer  
C P Diabetes  
C P Measles  
C P Stroke  
C P Rheum.Fever  
C HIV/AIDS

#### Cardio-Vascular

C P Hard. Of Arteries  
C P High Blood Pressure  
C P Low Bld. Pressure  
C P Rapid/Slow Heartbt.  
C P Swelling of Ankles  
C P Arrythmia

#### Genito-Urinary

C P Bedwetting  
C P Frequent Urination  
C P Kidney Infection  
C P Painful Urination  
C P Prostate Trouble  
C P Kidney Stones

#### For Women Only

C P Cramps or Backache w/cycle  
C P Excessive Menstral Flow  
C P Irregular Cycle  
C P Lumps in Breast  
C P Pain w/intercourse  
C P Pelvic Inflammatory Disease

Please list any medications you are taking, (including OTC) \_\_\_\_\_

Please list any medications that you are allergic to: \_\_\_\_\_

Please list all surgeries and dates \_\_\_\_\_

Medical Physician's name \_\_\_\_\_

### Your Family History (some health problems are the result of familial tendencies)

<u>Family Member</u>	<u>Illnesses</u>	<u>Age (or)</u>	<u>Age Died</u>	<u>Cause of Death</u>
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Father \_\_\_\_\_

Mother \_\_\_\_\_

Brother(s) \_\_\_\_\_

Sister(s) \_\_\_\_\_

### Social History

Do you smoke?  Yes  No If yes, how may packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you consume alcoholic beverages?  Yes  No If yes, socially? Moderately? Daily? Rarely?

Do you exercise regularly?  Yes  No If yes, daily? 3x/week 1x/week Other (specify): \_\_\_\_\_

### In the event of an emergency...

Who should we contact? \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_