Medical History Information

Last Name: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one)

First Name: Middle Initial: Single / Mar / Div / Widow

What Do You Prefer To Be Called? _____ Birth date: Age: Sex:

Email:_____ / /

Newsletters and Reminder Appointments via email ok? Yes( ) No( )

Address: City: Zip code:

Home#( ) - Cell# ( ) - Soc Security# - -

Occupation: Employer: WRK #

Insurance Name(Auto) (Health)

Reason For Today's Visit (Chief Complaint)

What Caused Your Condition (be as specific as possible)

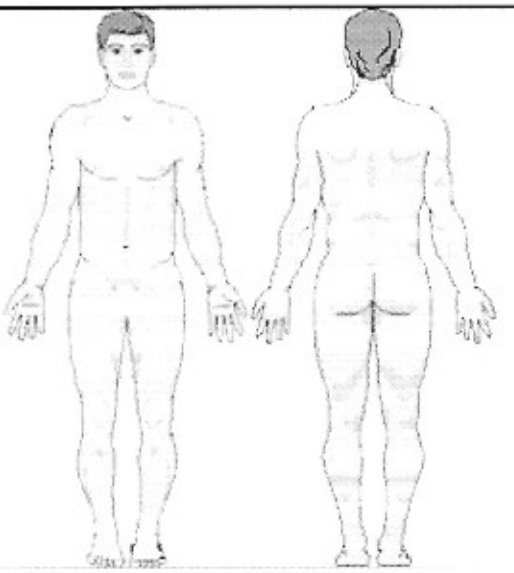
LIST AND MARK THE SEVERITY OF YOUR CONDITION ON THE SCALES BELOW:

BODY PART_____ _____

0(NONE) 5 (SEVERE) 10

BODY PART_____ _____

0(NONE) 5 (SEVERE)10



When Did Your Condition First Appear? (Specific date, days ago, etc)

Medical Care Information

Do You Have a Primary Care Physician? ☐ Yes ☐ No Name of Doctor:

Address: City: State: ZIP

Date of last Visit: / / Date of last exam: / /

Have You Ever Been Treated By A Chiropractor? ☐ Yes ☐ No If Yes By Whom?_____

The Reason For The Treatment?_____ Last Visit?_____

List **ANY** Past Accidents (even if not injured) With Dates_____

Have You Ever Had Any Surgeries? ☐ Yes ☐ No If Yes, Last Surgery Date:

Reason for Surgery:

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Due Date?_____ Are you nursing?☐ Yes ☐ No

Are you taking Birth Control? ☐ Yes ☐ No 1st date of last Menstrual cycle?_____

Your Current illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness: Mother/ Father/ Sister/ Brother

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis

Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week?____ (circle one) Light / Moderate / Strenuous

Misc.:

Are you taking any of the following medications? ☐ Anti Depressants ☐Blood Thinners ☐Tranquilizers ☐Insulin ☐Pain Killers

☐Muscle Relaxants ☐Anti-Inflammatories ☐Tylenol/Aspirin ☐Other(list please)

Insight Millennium Computerized Spinal Scanner

Our goal here at West Bay Chiropractic and Wellness Center is to be on the cutting edge of technology in order to provide you the best possible care. One part of your thorough evaluation here is a computerized Spinal Examination of your nerves and muscles. This state-of –the-art technology was developed by NASA and is Certified Space Technology. It will objectively help us detect areas of nerve disturbance, document and monitor your results and deliver the appropriate care.

While some insurance companies recognize this as a valuable part of a complete examination, your insurance company does not cover the cost of this test.

The cost to you for this test is $25.

This test may be repeated periodically to monitor your progress and guide your care.
The cost of each re-scan will be $15.
Again – this is not covered by your insurance plan and will be charged today in addition to your regular co-payment.

I have read and understand the policy above.

Patient Signature _____Date_____

This Office Provides Services in Addition to Conventional Chiropractic Treatment.
Please Indicate Your Interest in The Following By Placing a Check in The Appropriate Box.

SERVICE	INTERESTED	NOT INTERESTED	WOULD LIKE TO DISCUSS WITH DR
ACUPUNCTURE			
ALTERNATIVE MEDICINE			
BODY PURIFICATION/DETOX PROGRAMS			
CARPAL TUNNEL-NON SURGICAL TREATMENTS			
HEADACHE/MIGRAINE-NATURAL SOLUTIONS			
MASSAGE THERAPY			
NEUROMUSCULAR THERAPY			
NUTRITIONAL HEALTH ASSESMENT			
SPINAL DECOMPRESSION			

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.