GILL CHIROPRACTIC HEALTH CENTER, PA

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address _____**City**_____ **State**_____ **Zip** _____

Primary Phone_____**Secondary Phone**_____**Mobile Phone**_____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

❑ **Check here if you would like to receive monthly emails pertaining to health and wellness.**

❑ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Person to Contact in case of Emergency_____**Phone**_____

Primary Physician_____ **Phone**_____

How did you hear about our office? _____

GILL CHIROPRACTIC
HEALTH CENTER, PA

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

0 1 2 3 4 5 6 7 8 9 10

No interest *Very Interested*

Current medications, including dosage if known.

If there are no current medications, check here: ❑

	START DATE:		START DATE:
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known allergies you have had to any medications.

If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ❑ Yes❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ No ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

Today's Date / / **Signature of Patient** _____

To be completed by clinical staff:

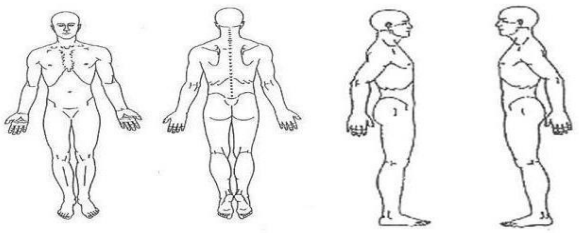
Height_____ Weight_____ BP _____/_____ Pulse_____

GILL CHIROPRACTIC HEALTH CENTER, PA

NAME _____DATE_____

CURRENT CONDITION

Mark the areas on this body where you are having problems. Use the appropriate symbols.



KEY: USE THE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

# - NUMBNESS	O - PINS & NEEDLES
X - BURNING	+ - DULL ACHE
/ - STABBING	* - PAIN

Describe your symptoms_____

When did your symptoms start? _____

What is the cause of your symptoms? _____

Indicate (circle) the average intensity of your symptoms. NONE 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

Frequency of symptoms: ☐Constant ☐Frequent ☐Intermittent ☐On and off ☐Random ☐Recurring

Have your symptoms changed? ☐Better ☐Worse ☐Same

NATURE OF SYMPTOMS:
☐Aching ☐Annoying ☐Burning ☐Dull ☐Sharp ☐Stabbing ☐Stiffness ☐Throbbing ☐Tightness ☐Tingling

ACTIVITY OF DAILY LIVING MOST AFFECTED:
☐Employment ☐Homemaking ☐Lifting ☐Personal Care ☐Sitting ☐Sleeping ☐Social life ☐Standing ☐Traveling ☐Walking

SYMPTOMS ARE RELIEVED BY:

☐Chiropractic Care	☐Cold Packs	☐Exercise	☐Heat Packs	☐Massage
☐OTC Medication	☐Prescription Medication	☐Physical Therapy	☐Rest	☐Stretching

SYMPTOMS ARE AGGRAVATED BY:

☐Any movement	☐Bathing	☐Bending	☐Caring for family	☐Carrying
☐Climbing stairs	☐Computer use	☐Coughing/sneezing	☐Driving	☐Sleeping
☐Getting out of car	☐Getting out of bed	☐Getting out of chair	☐Household chores	☐Lifting
☐Lying down	☐Pulling	☐Pushing	☐Reaching	☐Repetitive motions
☐Resting	☐Sitting	☐Squatting	☐Standing	☐Stress
☐Talking on phone	☐Turning/Twisting	☐Walking/Running	☐Working	☐Yardwork

Have you ever had this condition or a similar condition before? ☐ YES ☐NO

Type of care received: ☐None ☐Chiropractic care ☐ Medical care ☐ Medication ☐ Physical Therapy

What test have you had done? ☐X-ray ☐MRI ☐CT Scan ☐Other ☐None

REVIEW OF SYSTEMS:

Musculoskeletal:
☐ No musculoskeletal complaints
☐ Arthritis
☐ Back Problems
☐ Cramping
☐ Elbow/Wrist Pain
☐ Foot/Ankle Pain
☐ Fractures
☐ Gout
☐ Hip Disorders
☐ Implants, Plates, Pins or Screws
☐ Joint/Muscle Pain & Stiffness
☐ Knee Injuries
☐ Neck Pain
☐ Osteoporosis
☐ Pins or Screws
☐ Poor Posture
☐ Scoliosis
☐ Shoulder Problems
☐Swelling, redness of joints
☐ TMJ Issues
☐ Muscle Weakness
☐ Joints Replaced

Neurological:
☐ No neurological complaints
☐ Anxiety and/or Panic
☐ Depression
☐ Difficulty Concentrating
☐ Dizziness (ENT)
☐ Epilepsy or Seizures
☐ Headache
☐ Loss of Smell or Taste
☐ Memory Issues
☐ Numbness
☐ Sleeping Issues
☐ Stroke
☐ Head Injury
☐ Temporary Loss of Vision, Smell or Hearing
☐ Weak Muscles
☐ Brain Aneurysm
☐ Parkinson's Disease
☐ Loss of Balance

Head/Eyes/Ears/Nose/Throat
☐ No Complaints
☐ Blurred or Double Vision
☐ Chronic Ear Infections
☐ Dental Problems
☐ Difficulty Swallowing
☐ Ear or Hearing Problems
☐ Eye or Vision Problems
☐ Glaucoma
☐ Hoarseness
☐ Nose Congestion/Sinus Trouble
☐ Recent Hearing Loss
☐ Ringing In Ears
☐ Sore Throat
☐ Swollen Lymph Nodes
☐ TMJ problems

Cardiovascular
☐ No Cardiovascular Complaints
☐ Blood Clots
☐ Chest Pain or Tightness
☐ Congenital Heart Defects
☐ Coronary Artery Disease
☐ Dizziness
☐ Excessive Bruising
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ High Cholesterol or Triglycerides
☐ Leg Pain Upon Walking
☐ Low Blood Pressure
☐ Palpitations
☐ Rheumatic Fever
☐ Swollen Legs or Feet
☐ Varicose Veins
☐ Aortic Aneurysm
☐ Jaw Pain

Respiratory:
☐ No respiratory complaints
☐ Apnea
☐ Asthma
☐ Blood in Sputum
☐ Emphysema
☐ Hay Fever
☐ Persistent Cough
☐ Pneumonia
☐ Shortness of Breath
☐ Snoring Issues
☐ Tuberculosis
☐ Wheezing

Gastrointestinal:
☐ No Gastrointestinal Complaints
☐ Abdominal Pain
☐ Black or Bloody Stools
☐ Bloating
☐ Changes in Bowel Habits
☐ Colitis
☐ Colon Cancer or Polyps
☐ Constipation
☐ Crohn's Disease
☐ Difficulty Swallowing
☐ Food Sensitivities
☐ Gallbladder Problems
☐ Gastric Reflux
☐ Heartburn
☐ Hemorrhoids
☐ Irritable Bowel Syndrome
☐ Jaundice
☐ Liver Disease
☐ Nausea/Vomiting

☐ Pancreatitis
☐ Severe Diarrhea
☐ Ulcers

Genitourinary:
☐ No Genitourinary Complaints
☐ Blood in Urine
☐ Incontinence
☐ Kidney Stone
☐ Painful or Frequent Urination
☐ Sexual Dysfunction
☐ Urgency
☐ Urinary Infections
☐ Kidney Disease

Endocrine:
☐ No Endocrine Complaints
☐ Cushing's Syndrome
☐ Diabetes
☐ Excessive Thirst
☐ Feeling Hot or Cold
☐ Heat or Cold Intolerance
☐ Hyperparathyroidism
☐ Hypothyroidism
☐ Increased Urination
☐ Pancreatic Conditions
☐ Steroid Treatments
☐ Testosterone Deficiency
☐ Thyroid Problems
☐ Menopausal
☐ Menstrual Problems

Dermatological
☐ No Dermatological Complaints
☐ Change in Hair or Nails
☐ Easy Bruising
☐ Eczema
☐ Excessive Acne
☐ Excessive Hair Loss
☐ Flushing
☐ Gum Bleeding
☐ Psoriasis
☐ Skin Cancer
☐ Skin Trouble or Rashes

MEDICAL & SOCIAL HISTORY

Surgical History:
☐ No Surgical History
☐ Appendectomy ☐Cardiac Bypass ☐ Cardiac Valve Replacement ☐Carpal Tunnel-Left or Right
☐ C-section ☐Cosmetic Surgery/Implants ☐ Gastric Bypass ☐ Hysterectomy -Full or Partial
☐ Knee-Left or Right ☐Mastectomy ☐ Shoulder – Left or Right ☐ Spinal Fusion
☐ Spinal surgeries ☐Laminectomies ☐ Radical prostatectomy ☐Transurethral prostate surgery

Past Illnesses or Conditions:
☐ No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)
☐ AIDS/HIV ☐ Alzheimer's ☐ Anemia ☐ Anorexia/Bulimia
☐ Arthritis ☐ Asthma ☐ Bleeding Disorders ☐ Bronchitis
☐ Cancer ☐ Depression ☐ Diabetes ☐ Emphysema
☐ Epilepsy ☐ Fractures ☐ Heart Disease ☐ Hepatitis
☐ Hernia ☐ Herniated Disc ☐ High Blood Pressure ☐ High Cholesterol
☐ Hospitalization ☐ Kidney Disease ☐ Liver Disease ☐ Migraine Headaches
☐ Multiple Sclerosis ☐ Neuromuscular Issues ☐ Osteoporosis ☐ Pacemaker
☐ Parkinson's Disease ☐ Pinched Nerve ☐ Pneumonia ☐ Prostrate Problems
☐ Psychiatric Care ☐ Rheumatoid Arthritis ☐ Stroke ☐Thyroid Problems
☐ Trauma/Injury ☐ Tumor ☐ Venereal Disease ☐ Other _____

Past History of Accident or Trauma
☐ No Previous Trauma Reported
☐ Single Automobile Accident ☐ Multiple Automobile Accidents ☐ Slip and Fall ☐ Multiple Slip and Falls
☐ Single Motorcycle Accident ☐ Multiple Motorcycle Accidents ☐ Resulting in Fracture(s) ☐ Resulting in Hospitalization
☐ Resulting in Permanent Injury or Disability ☐ Resulting in Loss of Consciousness
☐ Resulting in No Significant Injury or Loss ☐ Resulting in Sprain/Strain

Family Health History:
☐ No Family History of Diabetes, Cancer, Hypertension and Progressive Neurological Disorders
☐ AIDS/HIV ☐ Alzheimer's ☐ Anemia ☐ Anorexia/Bulimia
☐ Arthritis ☐ Asthma ☐ Bleeding Disorders ☐ Bronchitis
☐ Cancer ☐ Depression ☐ Diabetes ☐ Emphysema
☐ Epilepsy ☐ Fractures ☐ Heart Disease ☐ Hepatitis
☐ Hernia ☐ Herniated Disc ☐ High Blood Pressure ☐ High Cholesterol
☐ Hospitalization ☐ Kidney Disease ☐ Liver Disease ☐ Migraine Headaches
☐ Multiple Sclerosis ☐ Neuromuscular Issues ☐ Osteoporosis ☐ Pacemaker
☐ Parkinson's Disease ☐ Pinched Nerve ☐ Pneumonia ☐ Prostrate Problems
☐ Psychiatric Care ☐ Rheumatoid Arthritis ☐ Stroke ☐Thyroid Problems
☐ Trauma/Injury ☐ Tumor ☐ Venereal Disease ☐ Other _____

Work Habits:
☐ No Change in Work Habits Since Condition Began ☐ Cannot Work Due To Presenting Condition
☐ Permanently Disabled ☐ Partially Disabled
☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐Student ☐Unemployed
☐ Mostly Sitting ☐ Mostly standing ☐Mostly Walking ☐Light Labor ☐Moderate Labor ☐Heavy Labor
☐ Computer ☐ Repetitive ☐Telephone ☐ Difficult ☐ Relaxed ☐ Stressful

Social Habits:
☐ No change in social habits since condition began ☐ Do not smoke, drink alcohol or take recreational drugs
☐ Social Drinker ☐ Alcoholic ☐ Recovering Alcoholic
☐ Current Every day Smoker ☐ Current Someday Smoker ☐ Former Smoker ☐ Never Smoked Tobacco
☐ Do Not Drink Caffeine ☐ Drink 1-3 cups of caffeine per day ☐ Drink 4 or more cups of Caffeine per day
☐ Does not use recreational drugs ☐ Use Recreational Drugs ☐ Recovering Drug Addict

Exercise Habits:
☐ No changes in exercise habits since condition began
☐ Daily ☐ None ☐ Every Other Day ☐ Few Times per week ☐ Once a Week ☐ Almost Nothing
☐ Biking ☐ Golf ☐ Stretching ☐ Yoga ☐ Racquetball/Tennis ☐Running
☐ Skiing ☐ Soccer ☐ Swimming ☐ Weight Lifting

Diet and Nutritional Status:
☐ No changes in diet or nutrition since condition began
☐ 1 to 2 meals a day ☐ 2 to 3 meals a day ☐ More than 3 meals a day
☐ Binges ☐ Purges ☐ Balanced ☐ High Protein ☐ Low Carbohydrate ☐ Low Fat
☐ Low Cholesterol ☐ No Red Meat ☐ Diabetic ☐ Gluten Free ☐ Paleo ☐ Vegan
☐ Vegetarian ☐ Zone ☐ Weight Watchers ☐Does not take daily supplements ☐Takes Daily Supplements