84 Chiropractic Center

Health History Form

Today's Date: _______ /________ / ________

Patient Data:

Name: First ____________________ **Middle Initial:** _____ **Last:** ___________________________

What you prefer to be called: ___________________________

Date of Birth: _______/_______/__________ **Sex:** M_____ F _____

Address: _______________________________ ________________ _______ _______

Street City State Zip

Home Phone: ( ) _______--_____________ **Work Phone: (**) _______--__________

Cell Phone: ( ) _______--_____________ **E-mail:** ______________________________

Height: _____________ **Weight:** ___________

Marital Status: Single___ Married___ Divorced___ Widowed___

Employment Status: F/T ___ P/T___ F/T Student__ P/T Student___ Other (specify) ___________

Employer Name: _________________________________

Spouse Name : _________________________________

Is your spouse a patient in this Clinic? Yes _____ No ______

Emergency Contact: Name ____________________________ Phone #: ( ) ______-- ________

Primary Care Physician Name: ________________________________ **Date of Last Visit:** ___/____/__

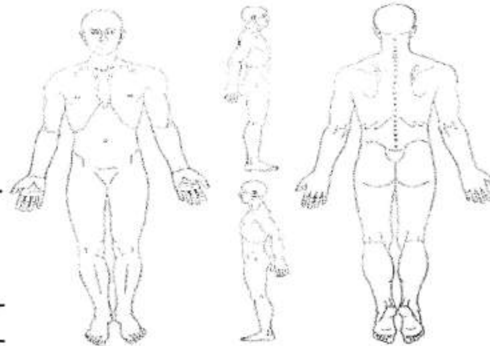
PCP Group Practice Name: __________________________

How did you hear about our Office? ____ Friend or Family If so, who? _______________________

____ PCP or MD If so, who? __________________________

____ other (Please Specify) ____________________________

Chief Complaint:



1. **Reasons for seeking chiropractic care** (Circle on Drawing)
   Primary Reason: ________________________________
   Secondary Reason: ______________________________
2. **When did your problem begin?** ____________________
3. **How did your problem begin?** ____________________
   ____
4. **Grade the Intensity:** 1 2 3 4 5 6 7 8 9
   (Mild) (Severe)
5. **Does anything aggravate the complaint?** ______________
   ____
6. **Does anything make the complaint better?** ______________________________________
7. **Describe the symptoms:** ___ Sharp ___Dull ___ Achy ___Burning ___Shooting ___Stabbing
   ___ Numb ___Tingling ___Deep ___Nagging ___Sharp w/ Movement
8. **How frequent is the complaint?** ___Constantly (76-100% of the day) ___Frequently (51-75%)
   ___ Occasionally (26-50%) ___ Intermittenly (0-26%)
9. **Have you had a history of similar symptoms that you are seeking care for in the past?**
   ___ Yes ____ No If yes, Please Explain____
   ____
10. **Are your symptoms the result of an Automobile or Work Injury?** ____ Yes ____ No
11. **Have you ever had chiropractic care before?** ___ Yes ___ No

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Health Questions:

1. Any Previous Injuries or Traumas (ex. Sports Injuries, Auto Accidents, Work Injuries, Falls, etc)
   (ex. Sports Injuries, Auto Accidents, Work Injuries, Falls, etc)
   ____
   ____

2. **List any medications that you are currently taking:**
   1. ____________________ Reason for taking ____________________
   2. ____________________ Reason for taking____________________
   3. ____________________ Reason for taking ____________________
   4. ____________________ Reason for taking ____________________

3. **List any nutritional supplements that you are taking:**
   1. ____________________ Reason for taking ____________________
   2. ____________________ Reason for taking ____________________
   3. ____________________ Reason for taking ____________________
   4. ____________________ Reason for taking ____________________

5. **What is that you like to do most that your condition is keeping you from doing?** ______________
____

Please read each statement and initial your agreement:

______ I instruct the treating providers of ProCare Chiropractic Center to deliver care that, in their professional judgement, can best help me in the restoring my health.

______ I may request a copy of the HIPAA Privacy Policy. I understand how my personal health information is protected and released on my behalf for seeking reimbursement from any involved 3rd party.

______ I grant permission to be called to confirm or reschedule an appointment. And to be sent occasional cards, letters, emails as an extension of my care in this office

______ I acknowledge that any insurance that I have is an agreement between the carrier and myself. And that I am responsible for payemnt of any covered or non-covered services that I receive

______ To the best of my ability, I have supplied the most compete and truthful information. I have not misrepresented the presence, severity or cause of my health concern.

Patient Signature ______________________________ ______________ **Date:** _____ /_____ / ______
(Parent or Guardian)

Name: ________________________ Date: __________

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary:

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic:

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic:

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory:

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat:

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes:

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary:

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric:

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic:

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal:

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal:

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine:

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

PLEASE COMPLETE REVERSE SIDE

Medical/Social History:

Please check all that apply :

Medical Conditions:

	Yes	No
Arthritis		
Hypertension		
Cancer		
Psychiatric illness		
Diabetes		
Skin Disorder		
Heart Disease		
Stroke		

Surgeries:

	Yes	No
Appendectomy		
Hysterectomy		
Right Ovary Removed		
Cardiovascualr Procedure		
Joint Replacement		
Transuretheral Prostate		
Cervical disc procedure		
Gallbladder Removed		
Laminectomies		
Radical Prostatectomy		

Allergies:

	Yes	No
Animal		
Peanut		
Eggs		
Soy		
Fish & Shellfish		
Sulfites		
Milk or Lactose		
Whaet/Gluten		

Social History:

	Occasional	Often	Never
Caffeine use			
Drink Alcohol			
Exercise			
Wear Seatbelt			
Chew Tobacco			
Smoke 1 pack a day			
Experience Stress			

Family History:

	Parent	Sibling	No
Arthritis			
Cholesterol			
Heart Problems			
Psychiatric			
Thyroid			
Cancer			
Diabetes			
High Blood Pressure			
Stroke			

Substance Abuse:

	Present	Past	No
Alcohol			
Amphetamines			
Barbiturates			
Cocaine			
Crystal Meth			
Heroin			
Marijuana			

Male Children:

	Yes	No
Under 6 Years		
Under 10 Years		
Under 19 Years		

Female Children:

	Yes	No
Under 6 Years		
Under 10 Years		
Under 19 Years		

Occupational Activities:

Administration	
Construction	
Healthcare	
Household	
Military	
Salesman	
Business Owner	
Daycare/Childcare	
Heavy Equipment Operator	
Light Manual Labor	
Police/Fire	
Teacher	
Clerical/Secretarial	
Executive/Legal	
Heavy Manual Labor	
Manufacturing	
Professional Services	
Truck Driver	
Computer User	
Food Service Industry	
Home Services	
Medium Manual Labor	
Retail Worker	

Recreational Activities:

Backpacking	
Coaching Sport	
Running	
Tennis	
Baseball	
Football	
Skiing	
Walking	
Biking	
Golf	
Soccer	
Weight Lifting	
Boating	
Racket Ball	
Swimming	