St. Ansgar CHIROPRACTIC

File #: _____

Patient Health History

Date: _____

In order to provide you the best possible chiropractic care, please complete this form as accurately as possible. All information is strictly CONFIDENTIAL.

PATIENT DATA

First Name: _____ M.I. _____ Last: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: (Home) _____ (Cell) _____ (Work) _____

Age: _____ Birth Date: _____ Social Security Number: _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name: _____ # of Children: _____

Occupation: _____ Employer/School: _____

Referred By: _____ or How did you hear about us? _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Medical Doctor: _____ City: _____ Phone #: _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name: _____ Date of Last Adjustment: _____

FINANCIAL INFORMATION

☐ I will be paying for the services myself. ☐ Health Insurance ☐ Auto Insurance ☐ Worker's Compensation ☐ Other

Insurance Company Name: _____

PURPOSE OF THIS VISIT

Reason for this visit: _____

When did your symptoms start? _____

How did you injure yourself? _____

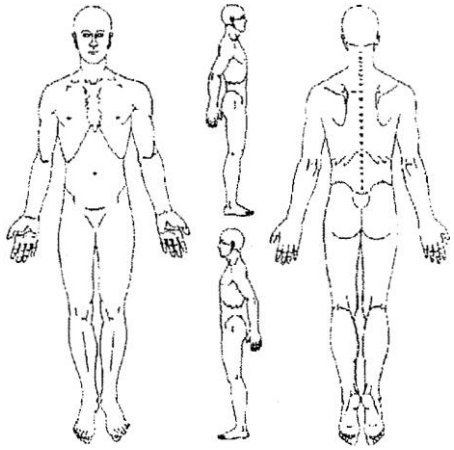
Please select all that apply:

☐ Achy	☐ Radiating	☐ Stabbing	☐ Constant (75-100% of the day)
☐ Burning	☐ Sharp	☐ Stiffness	☐ Frequent (50-75% of the day)
☐ Dull	☐ Shooting	☐ Tingling	☐ Intermittent (25-50% of the day)
☐ Numbness	☐ Soreness	☐ Other	☐ Occasional (0-25% of the day)

Intensity of your symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

The symptoms improve when I… _____

The symptoms worsen when I… _____



Comments: _____

_____

_____

Due to my current condition I have difficulty with:

☐ Sleeping ☐ Walking ☐ Sitting ☐ Standing ☐ Lifting ☐ Driving ☐ Dressing myself

☐ Turning my head to the (Rt, Lt, All) ☐ Climbing stairs ☐ Raising my (Rt, Lt) arm overhead

☐ Other: My ability to _____

Who have you seen for your symptoms? ☐ No one ☐ Chiropractor ☐ Surgeon ☐ MD ☐ Physical Therapist ☐ Other

What treatments/tests were performed? (X-rays, MRI's, etc.) _____

PAST HISTORY/SOCIAL HISTORY

Have you ever experienced this problem before? ☐ Yes ☐ No Please state: _____

Have you ever had any surgery? ☐ Yes ☐ No Please state: _____

Have you ever had any car accidents? ☐ Yes ☐ No Please state: _____

Sports injuries, falls, broken bones? ☐ Yes ☐ No Please state: _____

Do you take any medication? ☐ Yes ☐ No Please state: _____

Do you take any supplements? ☐ Yes ☐ No Please state: _____

Do you have any allergies? ☐ Yes ☐ No Please state: _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Poor

Do you smoke? ☐ Yes ☐ No # Packs per day: _____ If no, were you a former smoker? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No # Drinks per week: _____

Do you exercise? ☐ No ☐ Infrequently ☐ Occasionally ☐ Frequently ☐ Regularly Type of exercise?_____

Average hours worked per week: _____ hours Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Race: ☐ White (Caucasian) ☐ African American ☐ Asian ☐ Prefer not to disclose
☐ Alaska Native ☐ Pacific Islander ☐ American Indian

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer not to disclose

Please check all that you have or have had:

☐ AIDS	☐ Cold Extremities	☐ Headache	☐ Knee Replacement(s)	☐ Sinus Infection
☐ Alcoholism	☐ Concussion	☐ Heart Attack	☐ Loss of Memory	☐ Sleep Problems/Insomnia
☐ Allergies	☐ Constipation	☐ Heart Disease	☐ Loss of Balance	☐ Spinal Curvatures
☐ Anemia	☐ Depression	☐ Hemorrhoids	☐ Migraine Headache	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Neck Pain/Stiffness	☐ Swelling of Ankles
☐ Asthma	☐ Digestion Problems	☐ High Cholesterol	☐ Nervousness	☐ Thyroid Condition
☐ Back Pain	☐ Dizziness	☐ Hip Replacement(s)	☐ Pacemaker	☐ Tuberculosis
☐ Breast Lump	☐ Ringing in Ears	☐ Hot Flashes	☐ Polio	☐ Ulcers
☐ Bronchitis	☐ Excessive Menstruation	☐ Irregular Heart Beat	☐ Poor Posture	☐ Varicose Veins
☐ Bruise Easily	☐ Eye Pain/Difficulties	☐ Irregular Cycle	☐ Prostate Trouble	☐ Other: _____
☐ Cancer	☐ Fatigue	☐ Kidney Infection	☐ Sciatica	_____
☐ Chest Pain/Conditions	☐ Frequent Urination	☐ Kidney Stones	☐ Shortness of Breath	_____

Family History: Please note any family history of the following conditions and include relationship of relative to you:

☐ Cancer: _____ ☐ Arthritis: _____ ☐ Spine or Back Disorder: _____

☐ Diabetes: _____ ☐ Epilepsy: _____ ☐ Multiple Sclerosis: _____

☐ Headache: _____ ☐ Heart Disease: _____ ☐ Psychological Problems: _____

☐ High Blood Pressure: _____ ☐ Stroke: _____ ☐ Other: _____

The information that I have provided above is accurate to the best of my knowledge.

X Patient's Signature: _____