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Patient Medical History

Patient's Name: _____
 Date of Birth _____ Age _____ Weight _____ Height _____ Blood Pressure if known _____
 Problems with Anesthesia? Yes No If yes, explain _____

 DOA: _____ Type of Accident: Auto Workers Comp. Slip & Fall Other:

 Chiropractic Treatment # of visits: _____

INSURANCE INFORMATION

Auto ins.: _____ Type of Health Ins: () HMO () PPO (fill out below if PPO)
 Policy #: _____ Health Insurance Co: _____
 Claim #: _____ Policy #: _____
 Name of Insured: _____ Group #: _____
 Relationship to Insured: _____ Phone #: _____

PERSONAL INFORMATION (Please check all that apply)

<input type="checkbox"/> No Illnesses	<input type="checkbox"/> Common Cold	<input type="checkbox"/> Mental / Nervous Disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Diabetes	(Specify) _____	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Bladder / Kidney Infection	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Murmur / Valve Problem	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Bursitis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestinal Problems
Other: _____			

SOCIAL HISTORY

Do you smoke tobacco products? Yes, ___ pack(s) per day No
 Do you drink alcohol? Yes No Number of drinks per day? ___ per week? _____

FAMILY HISTORY (Siblings, parents and children)

<input type="checkbox"/> No Diseases	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Problems with Anesthesia	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	_____

PHARMACY

Name: _____
 Location: _____

Excessive Bleeding Tuberculosis _____
 Heart Disease _____ _____

Current Medication: <input type="checkbox"/> None _____ _____	Allergies / Difficulties with Medication & Reaction: <input type="checkbox"/> None Other _____
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PREVIOUS SURGERY: <input type="checkbox"/> None	Dates:
1. _____	_____
2. _____	_____
3. _____	_____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months):			
<input type="checkbox"/> None	<input type="checkbox"/> Chest X-ray	<input type="checkbox"/> Blood Work	<input type="checkbox"/> Stress Test
<input type="checkbox"/> Other _____			

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)		
General: <input type="checkbox"/> None	Head: <input type="checkbox"/> None	Respiratory: <input type="checkbox"/> None
<input type="checkbox"/> Fever	<input type="checkbox"/> Headaches	<input type="checkbox"/> Cough
<input type="checkbox"/> Chills	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Sputum
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Seizures	<input type="checkbox"/> Coughing up Blood
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Wheezing
Gastrointestinal: <input type="checkbox"/> None	Musculoskeletal: <input type="checkbox"/> None	Cardiovascular: <input type="checkbox"/> None
<input type="checkbox"/> Nausea	<input type="checkbox"/> Fracture	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sprain	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Pain / Difficulty Swallowing	<input type="checkbox"/> Strains	<input type="checkbox"/> Palpitation
<input type="checkbox"/> Gas Indigestion	<input type="checkbox"/> Dislocations	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> Swelling of Feet
<input type="checkbox"/> Bloating	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Night Cramps
<input type="checkbox"/> Constipation	<input type="checkbox"/> Joint Swelling	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Back pain	

FEMALE PATIENTS	
Is there any chance you are pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Patient's Signature: _____

Date: _____

Physician's Signature: _____

Date: _____