Patient Health History

Camanche Chiropractic Center

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

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

First Name_____ **Nick Name**_____

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

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____**Work Email** _____

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

Preferred 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 **# of Children**_____

Social Security # _____-_____-_____ **State & Driver's License #**___ _____

Employment Status *(check one)*

☐ Employed ☐ FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self Employed

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

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

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

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

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend?
☐ What is your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up?
☐ What was the make of your first car? ☐ When is your anniversary? ☐ What is your favorite color?

Answer to the Verification question (at least 8 characters): _

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐No, Never have smoked

How often do you smoke: ☐ Current every day smoker **IF Former**, year quit: _____

☐ Current sometimes smoker # years smoked_____

Number of packs per day: _____

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 list, *including dosage and start date* **if known.** **Name of pharmacy**_____

If there are no current medications, check here: ☐

1) _____ **5)** _____
2) _____ **6)** _____
3) _____ **7)** _____
4) _____ **8)** _____

List any known ALLERGIES you have to any MEDs/food & Reaction. If no allergies are known, check: ☐

1) _____ **3)** _____
2) _____ **4)** _____

Briefly list your main health problem(s): _____

_____

Has any doctor diagnosed you with Hypertension/High Blood Pressure presently? ☐ Yes ☐ No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ 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 low back spine in the past 28 days? ☐ Yes ☐ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____/_____ Pulse_____

APPLICATION FOR TREATMENT

(Confidential) Case # _____

Name_____

Referred by _____ Family Dr's name (i.e. M.D.)_____

Previous Chiropractic Care Yes No When _____ Results_____

Prev.Chiropractic Dr's Name_____

Occupation_____Employer_____Phone(Work)_____Ext._____

Previous occupations:_____

Primary Insurance Company _____ Policy # _____

Spouse/Secondary Insurance Co. _____ Policy #_____

Spouse (Parent if minor) Name_____ Age_____ Date of Birth ____/____/____

Occupation_____Employer_____Phone(Work)_____Ext._____

Do you suffer from any condition other than that for which you are now consulting us? Yes No What?_____

Surgeries, Procedures, and Hospitalizations (Please check and approximate date)

DATE		DATE		DATE		HOSPITALIZATIONS:
_____ ___	Vaccinations	_____ ___	Tubes in Ears	_____ ___	Sinus	_____
_____ ___	Tonsillectomy	_____ ___	Appendectomy	_____ ___	Hernia	_____
_____ ___	Gall Bladder	_____ ___	Female Organs	_____ ___	Thyroid	_____
_____ ___	Back Operation	_____ ___	Rectal Surgery	_____ ___	Stomach	_____
_____ ___	Other _____	_____ ___	Other _____	_____ ___	Other _____	

_____ I have never had any operations/surgeries.

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? (Check all you've had)

__ 541 Appendicitis	__ 280 Anemia	__ 429.9 Heart Disease	__ 716 Arthritis
__480 Pneumonia	__ 055 Measles	__ 240 Goiter	__ 345 Epilepsy
__390 Rheumatic Fever	__ 072 Mumps	__ 487 Influenza	__ 319 Mental Disorder
__ 045 Polio	__ 052 Chicken Pox	__ 511 Pleurisy	__ 724.2 Low back pain
__ 011 Tuberculosis	__ 250 Diabetes	__ 305.0 Alcoholism	__ 690 Eczema
__ 033 Whooping Cough	__ 239 Cancer	__ 099 Venereal Infection	__ 044 HIV Positive

List any/all accidents or falls and dates: ____ Car _____ ____ Recreational Vehicle _____

__ Sports _____ __ School _____ __ Accident_____ ____Other_____

List any broken bones (fractures) or dislocations: _____ ____ **I have never been injured.**

Ever on crutches? Yes No When & Why?_____ _____

Have you ever had any spinal taps or spinal injections? Yes No When_____

Any cuts, injections, broken skin in past 2 months? _____

Were you ever knocked unconscious? Yes No Have you ever had a lapse of memory? Yes No _____

Have you ever had Spinal X-rays taken? Yes No Date? _____ By Whom? _____

For what ailments were these X-rays made? _____

Recent Lab tests & results: _____

SOCIAL:

Alcohol consumption amount:_____ Coffee_____ Pop _____ Water_____

Sleep amount (hrs)_____ Pain reliever frequency _____ Recreational drug use _____

Eating:(Poor) 1 2 3 4 5 6 7 8 9 10 (Healthy) Stress: Physical: 0 1 2 3 4 5 6 7 8 9 10 (Severe) Emotional: 0 1 2 3 4 5 6 7 8 9 10

Exercise Freq.: _____ Types _____ /NOW:\ /PRIOR:\

RECREATION: Activity_____ Frequency_____ Difficulty: Easy 0 1 2 3 4 5 6 7 8 9 10 Hard 0 1 2 3 4 5 6 7 8 9 10

Activity_____ Frequency_____ Difficulty: Easy 0 1 2 3 4 5 6 7 8 9 10 Hard 0 1 2 3 4 5 6 7 8 9 10

Activity_____ Frequency_____ Difficulty: Easy 0 1 2 3 4 5 6 7 8 9 10 Hard 0 1 2 3 4 5 6 7 8 9 10

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any reasonable necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to Doctor for X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The entire balance is due thirty (30) days from the date of this statement. A finance charge of 1.5% per month (18% per year) will be charged and added to any unpaid balance not paid within ninety days.

Patient's/Guardian's Signature X _____ Date _____

Name_____ Case History Page 2

Please mark a **zero, one, or two** in the space in front of *EVERY* item below. **0=Never, 1=Previously, 2=Presently (or very recent).**

GENERAL SYMPTOMS

__ 995.3 Allergy (What)_____
_____
_____

__ 780.9 Chills
__ 780.3 Convulsions
__ 780.4 Dizziness
__ 780.2 Fainting
__ 780.7 Fatigue
__ 780.6 Fever
__ 784.0 Headache
__ 780.52 Loss of Sleep
__ 783 Loss of Weight
__ 799.2 Nervousness
__ 729.2 Neuralgia-nerve pain
__ 780.8 Night Sweats
__ 782 Numbness, Tingling or Pain in arms/legs/hands (circle)

GASTRO-INTESTINAL

__ 787.3 Belching or Gas
__ 789.0 Colon Trouble
__ 564.0 Constipation
__ 558.9 Diarrhea
__ 783.6 Excessive Hunger
__ 575.9 Gall Bladder Trouble
__ 455.6 Hemorrhoids (Piles)
__ 782.4 Jaundice
__ 794.8 Liver Trouble
__ 787.0 Nausea
__ 536.8 Pain over Stomach
__ 783.0 Poor Appetite
__ 536.8 Poor Digestion
__ 787.0 Vomiting
__ 578.0 Vomiting Blood

EYE/EAR/NOSE/THROAT

__ 493.9 Asthma
__ 378.9 Crossed Eyes
__ 389.9 Deafness
__ 388.70 Earache
__ 388.60 Ear Discharges
__ 388.30 Ear Noises
__ 240.9 Enlarged Thyroid
__ 460 Frequent Colds
__ 477.9 Hay Fever
__ 784.49 Hoarseness
__ 478.1 Nasal Obstruction
__ 784.7 Nose Bleeds
__ 379.91 Pain in Eyes
__ 368.9 Poor Vision
__ 473.9 Sinusitis
__ 462 Sore Throats
__ 463 Tonsillitis

RESPIRATORY

__ 786.50 Chest Pain
__ 786.2 Chronic Cough
__ 786.09 Difficulty Breathing
__ 786.3 Spitting Blood
__ 786.4 Spitting Phlegm
__ 786.09 Wheezing
__ 491 Bronchitis

GENITO-URINARY

__ 788.3 Bed Wetting
__ 599.7 Blood in Urine
__ 788.4 Frequent Urination
__ 788.3 Inability to Control Urine
__ 590.9 Kidney Infection
__ 788.1 Painful Urination
__ 601.9 Prostrate Trouble

MUSCLES & JOINTS

__ 724.5 Backache
__ 719.7 Foot Trouble
__ 550.0 Hernia
__ 719.1 Pain Between Shoulders
__ 724.6 Painful Tail Bone
__ 723.9 Stiff Neck
__ 781.9 Spinal Curvature
__ 719.0 Swollen Joints
__ 781.0 Tremors

CARDIO-VASCULAR

__ 401.9 High Blood Pressure
__ 458.9 Low Blood Pressure
__ 786.51 Pain over Heart
__ 785.9 Poor Circulation
__ 438 Previous Heart Trouble
__ 785.0 Rapid Heart
__ 427.89 Slow Heart
__ 436 Strokes
__ 782.3 Swelling Ankles
__ 454 Varicose Veins

SKIN OR ALLERGIES

__ 690 Boils
__ 924.9 Bruising Easily
__ 701.1 Dryness
__ 691.8 Eczema
__ 708.9 Hives or Allergy
__ 698.9 Itching
__ 782.0 Sensitive Skin
__ 368.9 Skin Eruptions

FOR WOMEN ONLY

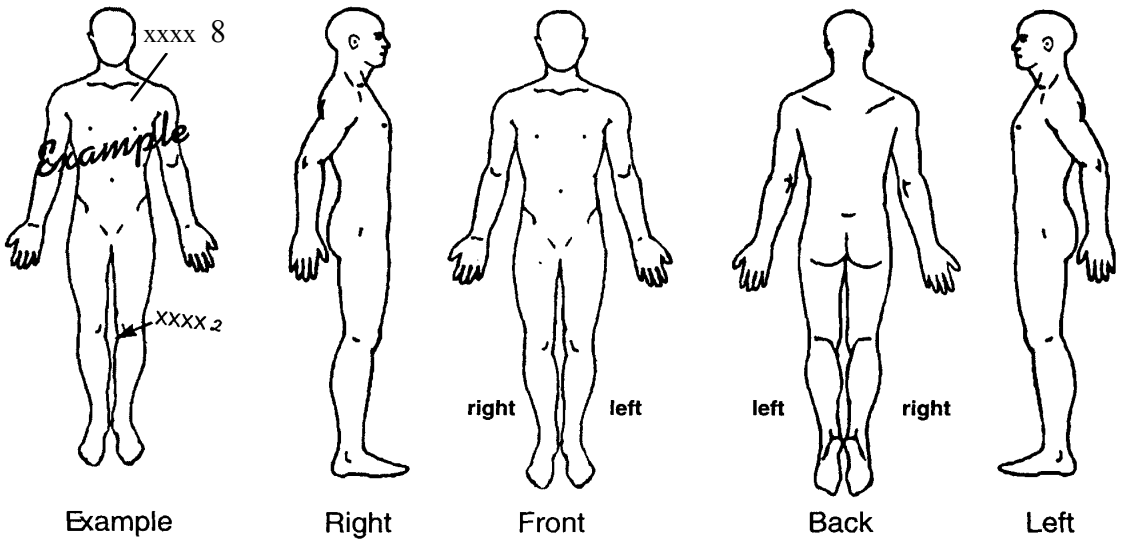
__ 625.3 Cramps/Backaches
__every month __alternates
__ 626.2 Excessive Flow
__ 627.2 Hot Flashes
__ 626.4 Irregular Cycle
__ 634.9 Miscarriage
__ 625.3 Painful Periods
__ 623.5 Vaginal Discharge
__No __ Pregnant at this Time
___/____Last Pap

Show us where it hurts

Please mark areas of symptoms as shown in example using a scale of 0=no symptom 10=severe.

Are your present problems due to an injury?
__Yes __ No
__On the Job
__Auto Accident
__Personal Injury (liability)
__ Other _____
Has the accident been reported __No __Yes
__To Employer
__Auto Carrier
__ Other _____
Are you now or have you ever been disabled? (Service or Work)? Yes No
When?_____
Have you retained an attorney? __No __Yes
Name & Address
_____
_____
_____

_____**Other** //////
Numbness -----
Pins & Needles OOOOO
Burning ^^^^^
Aching XXXXX
Stabbing ●●●●●



Example Right Front Back Left

Dietary Supplements:
_____
_____
_____
_____

FAMILY HISTORY (check)

	Diabetes	Heart	Back	Cancer	Living?	Age
Mother	__	__	__	__	__	____
Father	__	__	__	__	__	____
Brother, #___of__	__	__	__	__	__	____
Sister, #____of __	__	__	__	__	__	____