

CHIROPRACTIC CARE CENTER

CONFIDENTIAL PATIENT HEALTH COMPLAINT FORM

First Name _____ Initial _____ Last Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

S.S.# _____ - _____ - _____ Sex: Male / Female Email: _____

Marital Status (circle): Single / Married / Divorced / Widowed Referred by: _____

Age _____ Birthdate: ____ / ____ / ____ Occupation: _____ Employer: _____

Height _____ Weight _____ Spouse/Contact Name for Emergencies _____ Phone (____) _____

Chief Complaint: _____

Date complaint began: _____ What caused this problem? _____

Symptoms developed from: a work injury an auto accident other accident

Describe other complaints: *(please be specific)*

Involving neck & head: _____

Involving mid-back/shoulders/arms & hands: _____

Involving low back/hips/legs & feet: _____

What activities make conditions WORSE? _____

What activities made conditions BETTER? _____

Have you ever had this condition before? Yes No If yes, when? _____

Indicate ability to perform the following activities: Use codes U = Unable P = Painful L = Limited N = Normal

_____ Coughing	_____ Standing more than 1 hour	_____ Climbing	_____ Stooping
_____ Sneezing	_____ Sitting at a table	_____ Kneeling	_____ Gripping
_____ Bending forward	_____ Lying on back	_____ Balancing	_____ Pushing
_____ Turning over in bed	_____ Lying flat on stomach	_____ Dressing self	_____ Pulling
_____ Walking short distances	_____ Lying on side with knees bent	_____ Sleeping	_____ Reaching
			_____ Sexual activity

What type of recreational or exercise activities are you involved in? _____

Family History:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE	HIGH B.P.
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Women: Are you pregnant? Yes No Unsure / Possibly Date of your last menstrual cycle? (Date) _____

Check any of the following diseases you have had:

<input type="checkbox"/> Aids	<input type="checkbox"/> Malaria	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Infection	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Rheumatic <input type="checkbox"/> Fever
<input type="checkbox"/> Small Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Eczema	<input type="checkbox"/> Polio	

Check any of the following problems you have or have had in the past 6 months:

Muscles & Joints

- Low Back Pain
- Pain Between Shoulders
- Neck Pain/Stiffness
- Arm/Elbow/Wrist Pain
- Walking Problems
- Difficulty Chewing
- Clicking Jaw
- Leg/Knee/Foot Pain
- Hip Pain
- Pain in Tailbone

Nervous System

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold Extremities

General Problems

- Fatigue
- Night Sweats
- Frequent Colds
- Loss of Sleep
- Fever
- Headaches
- Weakness

- Black/Bloody Stool
- Colitis
- Poor Digestion

Kidney / Bladder

- Painful Urination
- Excessive Urine
- Discolored Urine
- Bedwetting
- Bad Urine Control

Eye, Ear, Nose & Throat

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose
- Ringing in Ears
- Nose Bleeds
- Sinus Trouble
- Swollen Glands
- Bronchitis

Heart & Lungs

- Wheezing
- Chest Pain
- Asthma
- Short Breath
- High Blood Pressure
- Low Blood Pressure
- Irregular Heart Beat
- Heart Surgery
- Lung Congestion
- Coughing
- Spitting Blood
- Varicose Veins
- Ankle Swelling

Stomach / Intestines

- Poor Appetite
- Excessive Appetite
- Excessive Thirst
- Nausea
- Vomiting
- Diarrhea
- Hemorrhoids/Piles
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Stomach Cramps
- Stomach Pain
- Gas / Bloating
- Heartburn

Men

- Prostate Pain
- Impotence
- Infertility

Women

- Menses Irregular
- Menstrual Cramps
- Vaginal Pain
- Breast Lumps
- Pain during sex
- Infertility
- Miscarriage

Have you ever been treated by a chiropractor? _____

When did you last see a doctor? _____ Last X-Rays? _____

What was the purpose of that visit? _____

Have you seen any other doctor for your present condition? Yes No

If yes, please give doctor's name and specialty: _____

Please list any surgeries you have had (include when and what for): _____

Please list any medications you are currently taking and what they are for (include prescription/ over the counter/ birth control / pain reliever): _____

Habits: Smoking Packs per Day _____ Alcohol Drinks per Day _____
 Coffee Cups per Day _____ Soda Cans per Day _____

PAYMENT INFORMATION

Clinic policy requires that payment is due at the time services are rendered. Our overall policy is that finances do not become a barrier for you to get the care you need. Please indicate below how you will be taking care of this account:

- Health Insurance
- Medicare
- Cash/Check/Credit Card
- Medicaid/ Title 19/ Forward
- Auto Insurance
- Worker's Compensation

CONSENT TO TREAT

The primary treatment used by doctors of Chiropractic is the spinal adjustment. We will use primarily that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. By signing below, you state that you are willing to undergo a chiropractic examination, x-rays of your spine (if indicated), and chiropractic treatment as may be outlined by the doctor after examination has been done.

Signature _____ Date _____

Consent to treat minor child _____ Date _____