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: _____

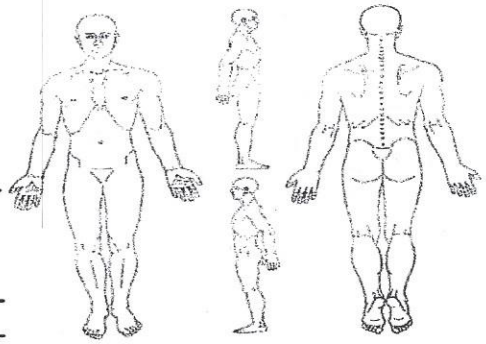
How did you hear about our Office? ____ Friend or Family If so, who? _____

____ 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

84 Chiropractic Center
Health History Form

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 84 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)