CONFIDENTIAL PATIENT HISTORY

Date: _____
Patient # _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Occupation _____ Employer _____

Spouse's Name _____ D.O.B _____ Spouse Ph _____ Employer _____

Children's Name & Ages _____

Have you had previous Chiropractic care? ☐yes ☐no Whom? _____

Who may we thank for referring you to our office? _____ ☐Walk In ☐Advertisement ☐Promotion ☐Yellow Pages

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

When doctors work together, it benefits you. May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ How Did it begin: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%

Have you ever experienced the same or similar symptoms? ☐yes ☐no When? _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? _____

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Drugs you now take: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other: _____

Do any family members suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ How Did it begin: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%

Have you ever experienced the same or similar symptoms ☐yes ☐no When? _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? _____

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Age of Mattress _____ ☐Comfortable ☐Uncomfortable

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

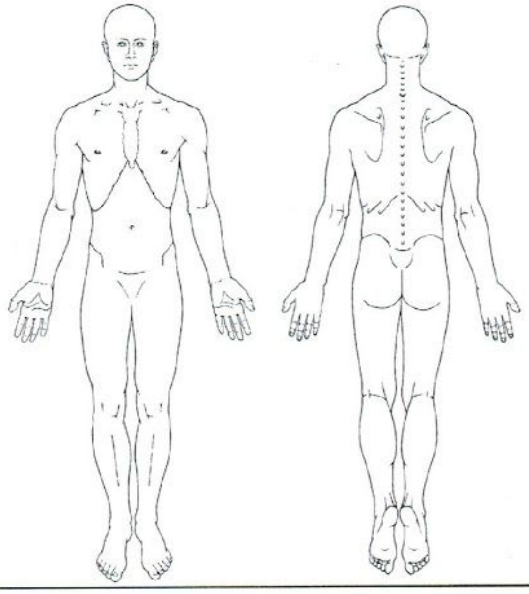
Please describe: _____

Please list all surgeries, injuries, accidents, falls, etc: _____

_____

Please mark off all areas of complaint on the diagrams with the following indicators:

AAA=ache
DDD=dull
NNN = numbness
TTT= tingling
BBB= burning
SSS=sharp/stabbing
XXX = other



Please list any medications or vitamins you are currently taking (including dosage).

_____
_____
_____
_____
_____
_____
_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____ **Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____
Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____
Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____
Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____
Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Is there any possibility that you may be pregnant? ☐yes ☐no **Date of Last Menstrual Cycle** _____

Please check if you have had any of the following:

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Arthritis	☐ Disc Degeneration	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Problems
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems
☐ Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Discover Chiropractic* will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Discover Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Date: _____
Patient # _____

Automobile Accident History

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Occupation _____ Employer _____

Spouse's Name _____ Business/Employer _____ Spouse Phone: _____

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

Date of Accident: _____ Time of Accident: _____ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

Was the accident on the job? ☐Yes ☐No Where you in a company vehicle? ☐Yes ☐No

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐Yes ☐No Did you experience a flash of light or explosion in your head? ☐Yes ☐No

Did the police come to the accident scene? ☐Yes ☐No Is there a police report? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No When? ☐Immediately ☐___hours later ☐___days later Which hospital? _____

How did you get to the hospital? _____ How long did you stay in the hospital? _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____

What areas were x-rayed? _____What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐Yes ☐No If yes, please complete information below.

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Were you wearing a seatbelt? ☐Yes ☐No If yes, did you receive any injury or bruise from the seat belt? ☐Yes ☐No

Did your head hit the head rest during the accident? ☐Yes ☐No If adjustable, was the position of the head rest altered? ☐Yes ☐No

Was the seat adjustment altered by the accident? ☐Yes ☐No Was the seat broken by the accident? ☐Yes ☐No

Did the air-bag deploy? ☐Yes ☐No If yes, did it strike you? ☐Yes ☐No If yes, where? _____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No If so, were they still on after the accident? ☐Yes ☐No

YOUR CAR

List the year, make and model of the car you were in: YEAR: _____ MAKE: _____ MODEL: _____

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: _____ MAKE: _____ MODEL: _____

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : _____mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim #:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim#:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** _____

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

1* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

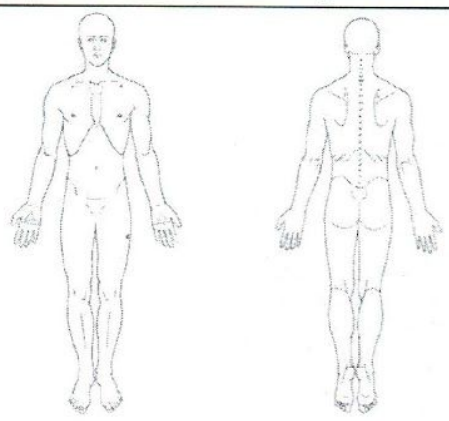
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



2* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

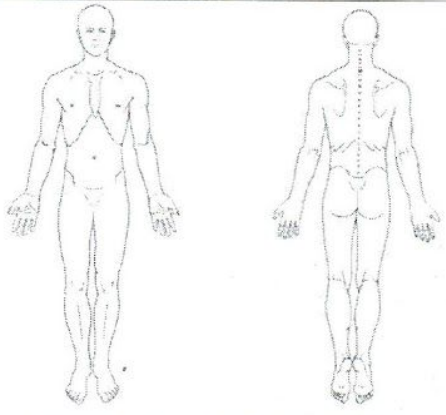
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



3* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

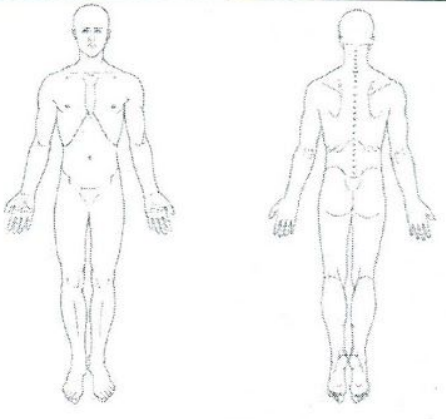
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing **How long?** _____ ☐Lifting **How much?** _____ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐Yes ☐No **If yes, how many days?** _____ **Dates:** _____

Are your work activities restricted as a result of this accident? ☐Yes ☐No **If yes, please explain.** _____

Do any of your work activities aggravate your present main complaints? ☐Yes ☐No **If yes, please explain.** _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____ **Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking (including dosage).

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

X-RAY CONFIRMATION - FEMALES

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature **Date**

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature **Date**

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Discover Chiropractic & Rehabilitation* and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print) _____

Name of Parent / Guardian (please print) _____

Parent / Guardian signature: _____ **Date:** _____