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: _____

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?

_____

Age of Mattress _____ € Comfortable € Uncomfortable

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

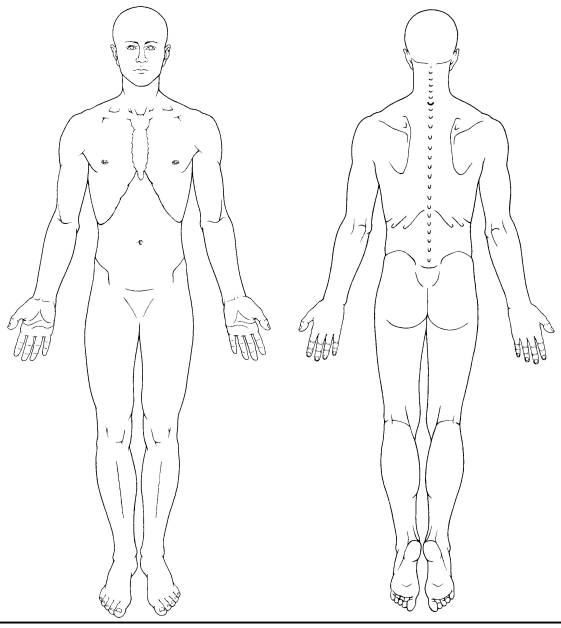
Please describe: _____

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?

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 *NeuroLogic Health* 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: _____