PRECISION CHIROPRACTIC

# ADULT CONFIDENTIAL HEALTH INFORMATION

## PATIENT INFORMATION *all fields required*

First Name:_____ Middle Initial:_____ Last Name: _____

Name you go by: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Last 4 of social: xxx-xx-_____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Spouse's Name: _____ # of Children _____

How did you hear about our office or who referred you? _____

## PHONE NUMBERS

Home: _____Cell: _____

Preferred appointment reminder: Email ☐ Cell ☐ Cell Carrier: _____

In case of emergency, notify: _____ Relationship: _____ Phone: _____

## PATIENT CONDITION

Chiropractic care is for optimal health and healing. However, most of our patients first seek our help when in a health crisis. What health concerns or crisis brought you to our office?

Reason for Visit_____

Is this due to an accident or injury? ☐ Yes ☐ No Type of Accident: Auto ☐ Home ☐ Other: _____

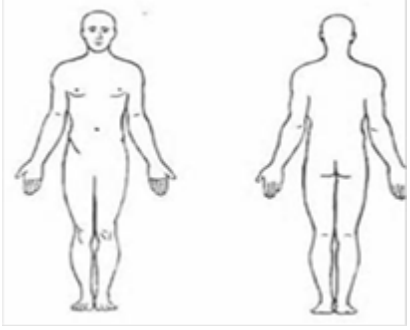
Is your condition getting worse? ☐Yes ☐No Has your condition been treated in the past by a doctor? ☐ Yes ☐ No

How long have you had the above problems? (If accident or injury, write date)_____

How often do you have the above problems?(Choose one)

☐ Weekly ☐ 25% of day ☐ 50% of day ☐75% of day ☐Constant/Daily

Rate your pain intensity from (circle) *None* 1 2 3 4 5 6 7 8 9 10 Severe



Does your pain interfere with your:

☐Daily Activites ☐Work ☐Sleep ☐Other_____

What aggravates your pain?:

☐Bending ☐Standing ☐Sitting ☐Walking ☐Recreation

Describe your pain: ☐ sharp ☐ dull ☐ throbbing ☐burning ☐ numb ☐ achy ☐ tingling ☐ radiating

What makes your condition better? _____worse? _____

**NEXT PAGE**

## HEALTH HISTORY

PLEASE CHECK ANY AND ALL PROBLEMS YOU HAVE HAD IN THE **LAST 2 YEARS**:

**General**

- ☐ Headaches
- ☐ Migraines
- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Dizziness
- ☐ Insomnia
- ☐ Fatigue
- ☐ Seizures
- ☐ Ringing in Ears
- ☐ Blurred Vision
- ☐ Sinus/Allergies
- ☐ Cancer (where?)

**Cardiovascular**

- ☐ Heart Attack/Stroke
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ High Cholesterol

**Musculoskeletal**

- ☐ Arthritis
- ☐ Scoliosis
- ☐ Swollen Joints
- ☐ Muscle Spasms
- ☐ Tingling/Numbness
- ☐ Muscle Weakness
- ☐ Radiating Pains
- ☐ Arm/Hand Pain
- ☐ Leg/Feet Pain

**GU/GI**

- ☐ Bowel Changes
- ☐ Bladder Changes
- ☐ Constipation
- ☐ Digestive Issues
- ☐ GERD/Reflux
- ☐ Prostate/Menstrual Changes

**Other**

- ☐ Leg Cramping
- ☐ Fibromyalgia
- ☐ Ear Infections/Aches
- ☐ Herniated Disc
- ☐ Pinched Nerve

**Any Other?**

_____
_____
_____
_____
_____

List Medications

_____ _____ _____

_____ _____ _____

## WORK & FAMILY HISTORY

Work related injuries can cause serious spinal problems. What is your occupation? _____

Any past or present health problems or diagnosis in another family member(s)? Yes ☐ No ☐

If YES, please explain: _____

## INSURANCE INFORMATION

Primary Insurance:_____ Policy No:_____ Group No:_____

Primary Subscriber Name:_____ Primary Subscriber DOB:_____

Secondary Insurance:_____ Policy No:_____

## FEMALES ONLY

Spinal health is especially important during pregnancy. Is there any chance you are pregnant? Yes ☐ No ☐

If YES, due date: _____ If NO, are you on Birth Control Pills? Yes ☐ No ☐

Check if any apply: ☐irregular menses ☐ severe menses ☐ miscarriage ☐ fertility challenges

_____ _____

Signature Date