

Date _____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ S.S.# _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____

Cell phone _____ e-mail address _____

Gender: Male Female Birth Date _____ Age _____

Employer _____ Occupation _____

Employment address _____

In case of emergency contact _____ Phone _____

Referred by _____ Have you ever been treated by a chiropractor before? Yes No

PCP name: _____ Phone number: _____

Would you like a report sent to him/her? Yes No

How would you describe your chief complaint at this time?

When did it start? _____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: Intermittent Constant

Have you had this problem in the past? _____ If so, how often? _____

Have you previously seen anyone for this condition? _____

Please list all previous treatments received _____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate? _____

When you engage in the physical activity noted above, what is the average duration of activity?

___ Less than 10 minutes ___ 10 – 20 mins ___ 20 – 30 mins ___ 30 – 60 mins ___ over 60 mins

When you engage in the physical activity noted above, what do you feel the level of effort is? _____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate? _____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Do you or other family members have a history of any of the following?

Arthritis	? <input type="checkbox"/> Self	Family member _____
Asthma	? <input type="checkbox"/> Self	Family member _____
Cancer	? <input type="checkbox"/> Self	Family member _____
Diabetes	? <input type="checkbox"/> Self	Family member _____
Heart Disease	? <input type="checkbox"/> Self	Family member _____
Hypertension	? <input type="checkbox"/> Self	Family member _____
Hypoglycemia	? <input type="checkbox"/> Self	Family member _____
Kidney Disease	? <input type="checkbox"/> Self	Family member _____
Depression	? <input type="checkbox"/> Self	Family member _____
Mental Illness	? <input type="checkbox"/> Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

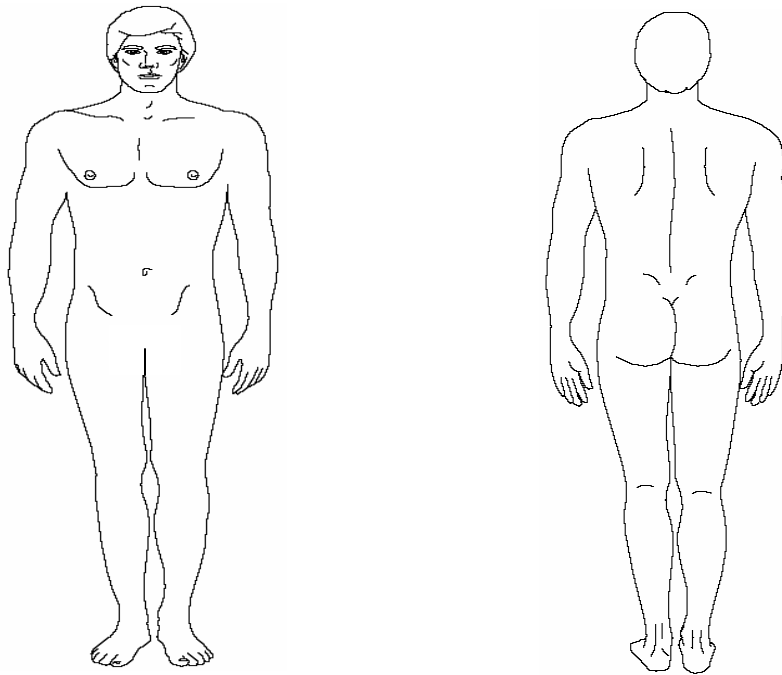
Do you drink alcohol? _____ If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

Name	Reason
_____	_____
_____	_____
_____	_____

Please list any allergies that you have.

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.



On a Scale from 0-10, with 10 being the worst pain you have experienced and 0 being no pain. What is your current scale of pain?

0 1 2 3 4 5 6 7 8 9 10

Financial Responsibility Statement

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment against Doctor's recommendations, my account balance will be immediately due and payable.

Patients Signature: _____ S.S#: _____

Date: _____