CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Chiropractic Wellness
Dr. Nancy Meyer

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Today's Date (MM/DD/YYYY) _____

File # _____

Whom may we thank for referring you? _____

Have you consulted a chiropractor before?
O **No** O **Yes** **When?** _____

If so, whom? _____

Your Last Name _____ **Your First Name** _____ **Your Middle Name (or Initial)** _____ **Nickname** _____

Address _____

Social Security # _____

Birth Date (MM/DD/YYYY) _____

Gender
O Male O Female

Marital Status
O Single O Married O Divorced O Widowed O Separated

Email Address _____

Emergency Contact Name & Phone # _____

Your Occupation _____

Your Employer _____

Employer Address _____

Spouse's Name _____ **Home Phone** _____

Children's Name & Age _____ **Cell Phone** _____

Children's Name & Age _____ **Phone** _____

Children's Name & Age _____ **May we contact you at work?** O Yes O No

Preferred method of contact?
O Home Phone O Cell Phone
O Work Phone O Email **Work Phone** _____

Primary Care Provider's Name _____

Insurance Carrier _____ **Policy Number** _____

Who carriers this policy?
O Self O Spouse O Parent

Insured's Last Name (if other than patient) _____ **Insured's Birth Date (MM/DD/YYYY)** _____

Insured's First Name _____ **Insured's Middle Name (or Initial)** _____

Insured's Employer _____ **Employers Phone Number** _____

Insured's Address _____

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____ **Patient name**

_____

2. Symptoms are the result of (check circle):
◯ An accident or injury: ◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset: When did you first notice your current symptoms?)
_____

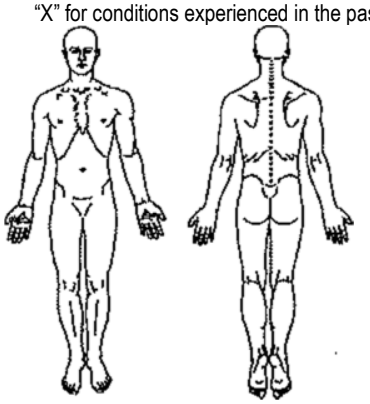
4. Describe onset: ◯ Acute ◯ Chronic ◯ Gradual ◯ Insidious ◯ Aggravation of chronic condition ◯ Other_____

5. Cause: ◯ Unknown ◯ Accident ◯ Other_____ **6. Prior pain:** ◯ None ◯ On & off for years ◯ Other_____

7. Side: ◯ Right ◯ Left ◯ Both (bilateral) **8. Is pain:** ◯ Improving ◯ Getting worse ◯ No change

9. Quality of symptoms (What does it feel like?)
◯ Achy
◯ Burning
◯ Dull
◯ Sharp
◯ Stiff
◯ Throbbing
◯ Deep
◯ Radiating
◯ Shooting
◯ Numbness
◯ Tingling
◯ Spasms
◯ Nagging
◯ Cramping
◯ Stabbing
◯ Other _____

10. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



_____

11. Description of symptoms: ◯ Mild ◯ Moderate ◯ Severe
◯ Very mild ◯ Mild to moderate ◯ Moderate to severe ◯ WNL

12. Intensity (How extreme are your current symptoms?)
Absent Uncomfortable Agonizing
0 **O-O-O-O-O-O-O-O-O-O** 10

13. Duration (How often does pain occur?)
◯ Constant (76-100%) ◯ Frequent (51-75%)
◯ Intermittent (26-50%) ◯ Occasional (1-25%)
How often? _____

14. Radiating to (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
_____

15. Prior Interventions (What have you done to relieve the symptoms?) ◯ Prescription medications ◯ Surgery
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic ◯ Ice
◯ Physical therapy ◯ Massage ◯ Other_____

16. Aggravation or relieving factors (What makes it better or worse such as time of day, movements, certain activities, etc.):
What tends to worsen the problem? _____
What tends to lessen the problems? _____

17. What else should Chiropractic Wellness know about your current condition: _____

_____

18. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

19. Review of systems

a. Musculoskeletal System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Osteoporosis	◯ ◯ Arthritis	◯ ◯ Scoliosis	◯ ◯ Neck pain	◯ ◯ Back problems	◯ ◯ Hip disorders	Initials___
◯ ◯ Knee injuries	◯ ◯ Foot/Ankle pain	◯ ◯ Shoulder problems	◯ ◯ Elbow/wrist pain	◯ ◯ TMJ issues	◯ ◯ Poor posture	

b. Neurological System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Anxiety	◯ ◯ Depression	◯ ◯ Headache	◯ ◯ Dizziness	◯ ◯ Pins & needles	◯ ◯ Numbness	Initials___

c. Cardiovascular System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ High blood pressure	◯ ◯ Low blood pressure	◯ ◯ High cholesterol	◯ ◯ Poor circulation	◯ ◯ Angina	◯ ◯ Excessive bruising	Initials___

d. Respiratory System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Asthma	◯ ◯ Apnea	◯ ◯ Emphysema	◯ ◯ Hay fever	◯ ◯ Shortness of breath	◯ ◯ Pneumonia	Initials___

e. Digestive System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Anorexia/bulimia	◯ ◯ Ulcer	◯ ◯ Food sensitivities	◯ ◯ Heartburn	◯ ◯ constipation	◯ ◯ Diarrhea	Initials___

_____
Doctor's Initials

(Continued from previous page)

Patient name _____

f. Sensory System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Blurred vision	◯ ◯ Ringing in ears	◯ ◯ Hearing loss	◯ ◯ Chronic ear infection	◯ ◯ Loss of smell	◯ ◯ Loss of taste	Initials___

g. Integumentary System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Skin cancer	◯ ◯ Psoriasis	◯ ◯ Eczema	◯ ◯ Acne	◯ ◯ Hair loss	◯ ◯ Rash	Initials___

h. Endocrine System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Thyroid	◯ ◯ Immune disorders	◯ ◯ Hypoglycemia	◯ ◯ Frequent infection	◯ ◯ Swollen glands	◯ ◯ Low energy	Initials___

i. Genitourinary System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Kidney stone	◯ ◯ Infertility	◯ ◯ Bedwetting	◯ ◯ Prostate issues	◯ ◯ Erectile dysfunction	◯ ◯ PMS symptoms	Initials___

j. Constitutional System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	None ◯
◯ ◯ Fainting	◯ ◯ Low libido	◯ ◯ Poor appetite	◯ ◯ Sudden weight gain/loss (circle one)	◯ ◯ Fatigue	◯ ◯ Weakness	Initials___

Past personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

20. Illnesses

Check the illnesses you have **Had** in the past of **Have** now.

Had Have	Had Have
◯ ◯ AIDS	◯ ◯ Tuberculosis
◯ ◯ Alcoholism	◯ ◯ Typhoid fever
◯ ◯ Allergies	◯ ◯ Ulcer
◯ ◯ Arteriosclerosis	◯ ◯ Other: _____
◯ ◯ Cancer	_____
◯ ◯ Chicken pox	_____
◯ ◯ Diabetes	_____
◯ ◯ Epilepsy	_____
◯ ◯ Glaucoma	_____
◯ ◯ Goiter	_____
◯ ◯ Gout	_____
◯ ◯ Heart disease	
◯ ◯ Hepatitis	
◯ ◯ HIV Positive	
◯ ◯ Malaria	
◯ ◯ Measles	
◯ ◯ Multiple Sclerosis	
◯ ◯ Mumps	
◯ ◯ Polio	
◯ ◯ Rheumatic fever	
◯ ◯ Scarlet fever	
◯ ◯ Sexually transmitted disease	
◯ ◯ Stroke	

15. Operations

Surgical interventions which may or may not have included hospitalization.

◯ Appendix removal
◯ Bypass surgery
◯ Cancer
◯ Cosmetic surgery
◯ Elective surgery: _____
_____
◯ Eye surgery
◯ Hysterectomy
◯ Pacemaker
◯ Spine _____
_____
◯ Tonsillectomy
◯ Vasectomy
◯ Other: _____
_____
_____
_____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control pills
◯	◯	Blood transfusions
◯	◯	Chemotherapy
◯	◯	Chiropractic care
◯	◯	Dialysis
◯	◯	Herbs
◯	◯	Homeopathy
◯	◯	Hormone replacement
◯	◯	Inhaler
◯	◯	Massage therapy
◯	◯	Physical therapy
◯	◯	Nutritional supplements:

List: _____
_____
_____

17. Injuries Have you ever…

◯ Had a fractured or broken bone
◯ Had a spine or nerve disorder
◯ Been knocked unconscious
◯ Been injured in an accident
◯ Used a crutch or other support
◯ Used neck or back bracing
◯ Received a tattoo
◯ Had a body piercing

◯ ◯ Medications (Prescription and over-the-counter)
_____
_____
_____

21. Family History

Some health issues are hereditary. Tell Chiropractic Wellness about the health of your immediate family members.

Relative	Age (if living)	State of health		Illness	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	◯	◯	_____	_____	◯	◯
Father	_____	◯	◯	_____	_____	◯	◯
Sister 1	_____	◯	◯	_____	_____	◯	◯
Sister 2	_____	◯	◯	_____	_____	◯	◯
Brother 1	_____	◯	◯	_____	_____	◯	◯
Brother 2	_____	◯	◯	_____	_____	◯	◯
_____	_____	◯	◯	_____	_____	◯	◯

22. Are there other hereditary issues that you know about?_____

_____

23. Social History (Tell Chiropractic Wellness about your health habits and stress levels.)

Alcohol use	◯ Daily ◯ Weekly	How much? _____	
Coffee use	◯ Daily ◯ Weekly	How much? _____	
Tobacco use	◯ Daily ◯ Weekly	How much? _____	
Exercising	◯ Daily ◯ Weekly	How much? _____	
Pain relievers	◯ Daily ◯ Weekly	How much? _____	
Soft drinks	◯ Daily ◯ Weekly	How much? _____	
Water Intake	◯ Daily ◯ Weekly	How much? _____	

Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

Hobbies_____

_____
Doctor's Initials

Patient name _____

24. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯	**Grocery shopping**	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯	**Household chores**	◯	◯	◯	◯
Standing	◯	◯	◯	◯	**Lifting objects**	◯	◯	◯	◯
Walking	◯	◯	◯	◯	**Reaching overhead**	◯	◯	◯	◯
Lying down	◯	◯	◯	◯	**Showering or bathing**	◯	◯	◯	◯
Bending over	◯	◯	◯	◯	**Dressing myself**	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯	**Love Life**	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯	**Getting to sleep**	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯	**Staying asleep**	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯	**Concentrating**	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯	**Exercising**	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯	**Yard work**	◯	◯	◯	◯

25. What is the major stressor in your life? _____ **26. How much sleep do you average per night?** _____Hours

27. What is the type and approximate age of your mattress and pillow? _____ **28. What is your preferred sleeping position?** _____

29. Describe your typical eating habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

30. What would be the most significant thing that you could do to improve your health? _____

_____

31. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

If the patient is a minor child, print child's full name: _____

_____ _____

Signature **Date (MM/DD/YYYY)**

_____

Doctor's Initials