

WELCOME!

Confidential Health History Form

Chiropractic Plus Pain to Wellness Center, PLLC

For Office Use Only
ID #

Please Present Insurance Cards & Photo Identification to Copy for Files.

PLEASE PRINT CLEARLY! Thank you! SIGN ALL PAGES!

First visit to our office? Yes No

Title (check one): Mr. Mrs. Ms. Miss Dr. Other _____

PATIENT NAME: First _____ MI _____ Last _____

IF MINOR, Parent/Guardian Name: _____
PRINT: First MI Last

Address: _____
Street / Apt City State Zip

Phone: Cell: _____ Home: _____ Work: _____

Email (We do not share/Please Print): _____

Your Age: _____ Date of Birth: _____ / _____ / _____ Your Gender: Female Male _____

Your Social Security Number: _____

You are: Divorced Married Live-in Partner Single Separated Widowed

Spouse/Partner Name: _____
PRINT: First MI Last

Names / Ages of Children: _____

Females: Are you pregnant? No Yes If Pregnant, # Weeks _____ / Due Date: _____

EMPLOYMENT INFORMATION:

Employment Status: Employed Unemployed FT Student PT Student Other _____

Occupation: _____

Occupational Activities (check best description/s of your job):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Home Services | <input type="checkbox"/> Health Care | <input type="checkbox"/> Food Service Industry |
| <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper | <input type="checkbox"/> Manufacturing |
| <input type="checkbox"/> Heavy Equipment Operator | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Heavy Manual Labor |

Other Job Description _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Address: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Internet Insurance Friend/Family Other _____

Name & Address of person we can thank for referral: _____

PATIENT SIGNATURE _____ **DATE** _____

**IF MINOR: PARENT/GUARDIAN NAME LISTED ABOVE
SIGNATURE & CONSENT TO EXAMINE/TREAT MINOR** _____

Attending Doctor's Signature _____ **Date** _____

Confidential Health History Form – page 2
 Chiropractic Plus Pain to Wellness Center, PLLC
REVIEW OF SYSTEMS

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PATIENT NAME: First _____ MI _____ Last _____

IF MINOR, Parent/Guardian Name: _____

PRINT: First MI Last

SIGNATURE: _____ **DATE:** _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Aortic Aneurism				Tuberculosis				Other Skin Disorder			
Heart Disease				Short Breath				Immune Disorder			
Heart Attack				Emphysema				HIV/AIDS			
Chest Pain				Cold/Flu				Allergy Shots			
Pace Maker				Cough				Cortisone Use			
Jaw Pain				Wheezing							
Atrial Fib								Ear, Nose and Throat	Past	Present	No
Swelling of legs				Eyes	Past	Present	No	Difficulty Swallowing			
				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary	Past	Present	No	Blurred Vision				Ear Aches			
Kidney Disease								Sore Throat			
Burn Urination				Psychiatric	Past	Present	No	Nosebleeds			
Often Urination				Depression				Bleeding Gums			
Blood in Urine				Anxiety				Sinus Infections			
Kidney Stones				Stress				Sore Throat			
Lower Side Pain											
				GastroIntestine	Past	Present	No	Endocrine	Past	Present	No
Neurologic	Past	Present	No	Gall Bladder				Thyroid			
Stroke				Liver Problems				Diabetes			
Brain Aneurysm				Constipation				Hair Loss			
Numbness				Diarrhea				Menopausal			
Severe Headaches				Bowel Problems				Menstrual			
Pinched Nerves				Ulcers				Vaginal Pain/Infection			
Parkinson's				Nausea/ Vomiting				Breast Pain/Lumps			
Carpal Tunnel				Hiatal Hernia				Prostate/Sexual Dysfxn			
Vertigo				Poor Appetite							
				Hemorrhoids							
Constitutional	Past	Present	No	Hematologic	Past	Present	No	Musculoskeletal	Past	Present	No
				Hepatitis				Gout			
Weight Loss/Gain				Blood Clots				Arthritis			
Low Energy				Cancer				Joint Stiffness			
Sleep Problems				Bruising				Muscle Weakness			
				Bleeding				Osteoporosis			
				Fever, Chills				Broken Bones			
				Sweating				Joints Replaced			
				Anemia							

Other Medical Condition: _____

Attending Doctor's Signature _____ **Date** _____

Confidential Health History Form – page 3
Chiropractic Plus Pain to Wellness Center, PLLC
MEDICATIONS / SURGERIES / FAMILY & SOCIAL HISTORY

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PATIENT NAME: First _____ MI _____ Last _____

IF MINOR, Parent/Guardian Name: _____
PRINT: First MI Last

SIGNATURE: _____ **DATE:** _____

Surgeries: (Check all that apply to you)

Brain Appendectomy Cardiovascular procedure Hysterectomy Prostate
 Cervical spine Thoracic spine Lumbar spine Gall Bladder
 Carpal Tunnel Shoulder Knee Foot/Ankle Joint Replacement
 Gastro-intestinal Uro-genital Hernia Other _____

Use of:

Orthotics/Shoe Inserts Cane Walker Mobile Cart Assist Other _____

Allergies: (Check all that apply to you)

Eggs Fish and Shellfish Milk or Lactose Peanuts Wheat/Glutens
 Soy Sulfites Other _____

Social History: (Check all that apply to you)

Caffeine use: occasional often never cups/day _____
Drink Alcohol: occasional often never drinks/week _____
Exercise: occasional often never type _____
Chew Tobacco: occasional often never
Cigarettes: less than 1 pack/day more than 1 pack/day never
Wear Seat Belts: occasional always never
Other _____

Family History: (Grandparents-Parents-Siblings / Check all that apply)

Arthritis: Parent Sibling Other _____
Cancer: Parent Sibling _____
Diabetes: Parent Sibling _____
Heart Disease: Parent Sibling _____
Hypertension: Parent Sibling _____
Stroke: Parent Sibling _____
Thyroid: Parent Sibling _____

BIOCHEMICAL HEALTH / CURRENT MEDICATIONS & NUTRITIONAL SUPPLEMENTS (Continue other side if needed)

Please list ALL **DRUGS** you currently take or have taken in the past 6 months:

Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____

Please list all **NUTRITIONAL SUPPLEMENTS, VITAMINS, HOMEOPATHIC REMEDIES** you presently take:

Your Primary Care Physician:

Name _____ City/State _____ Phone _____

Date of Your Last Exam: Medical: _____ Chiropractic: _____

Rev 11/16/2015

Attending Doctor's Signature _____ **Date** _____

Patient Name _____ **Date** _____

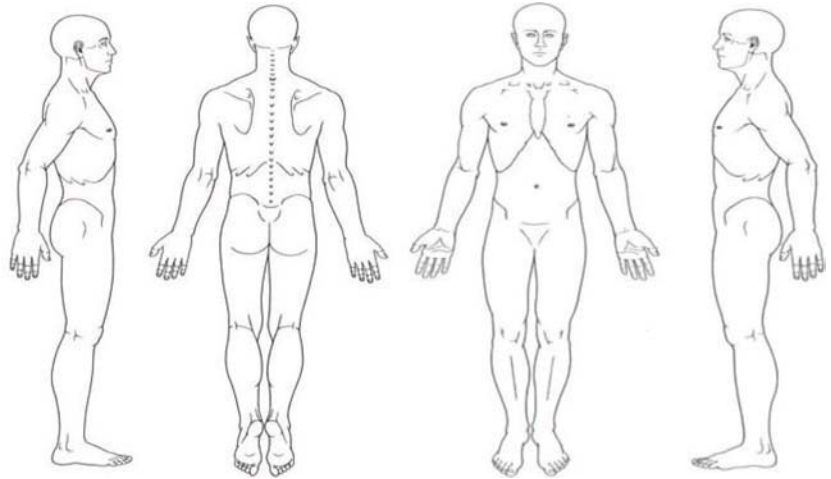
1. Describe your symptoms _____

a. Date your symptoms began: _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)*Plan*

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No
- ③ This Office
- ④ Chiropractor
- ⑤ Medical Doctor
- ⑥ Physical Therapist
- ⑦ Other

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ **Date** _____

Confidential Health History Form – Page 5

Chiropractic Plus Pain to Wellness Center PLLC
ADL, EMPLOYMENT, AND RECREATION INFORMATION

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PATIENT NAME: First _____ MI _____ Last _____

IF MINOR, Parent/Guardian Name: _____

SIGNATURE: _____ DATE: _____

Description of Work: _____

Condition's Effect On Job Performance: No Effect Mild (painful can do) Mod (painful limited ability)
 Mod/Sev (limited duty) Sev (no limited duty) Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Change Posn–Sit-Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Self Care–Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

_____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

_____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

What activities would you like to do that you cannot do because of your pain, illness, condition?

Attending Doctor's Signature _____ Date _____

Outcomes Assessment Tool Used _____ Score _____
_____ Score _____

Confidential Health History Form – page 6
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INSURANCE INFORMATION

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PATIENT NAME: First _____ MI _____ Last _____

IF MINOR, Parent/Guardian Name: _____

SIGNATURE: _____ **DATE:** _____
PRINT: First MI Last

INSURANCE CLAIM INFORMATION

IS THIS A CLAIM TO FILE WITH: ___ Health Insurance ___ Auto Insurance
___ Medicare ___ Worker's Comp

Other: _____

IF WORKER'S COMPENSATION INJURY:

Have you filed an injury report with your employer? ___ Yes ___ No Date: ___/___/___ Time: ___ am / pm

IF PERSONAL PRIVATE OR MEDICARE HEALTH INSURANCE:
~Present Insurance Policy Cards & Photo Identification to Copy~

PRIMARY Insurance Company Name: _____

Policy Holder Name (PRINT): _____

Policy Holder: ___ You, ___ Your Child, ___ Your Parent, Other _____

Policy Holder's Birth Date ___/___/___

SECONDARY Insurance Co Name: _____

Policy Holder Name (PRINT): _____

Policy Holder: ___ You, ___ Your Child, ___ Your Parent, Other _____

Policy Holder's Birth Date ___/___/___

IF AUTOMOBILE-VEHICLE ACCIDENT:
~Present Insurance Policy Card & Photo Identification to Copy~

I have a Police Report: ___ Yes ___ No If No Report, Why _____

Auto Accident Date: ___/___/___ Accident State: ___ NC Other State _____

YOUR Auto Policy Carrier: _____ YOUR Auto Policy # _____

YOUR CLAIM # _____ Your Agent: _____ Phone: _____

AT-FAULT Driver Name: _____ CLAIM # _____

AT-FAULT Auto Policy Co: _____ Their Auto Policy # _____

AT-FAULT Co Agent Name: _____ Phone: _____

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HIPAA PRIVACY PRACTICES – MUST SIGN!!

I acknowledge that I have seen online the
Notice of HIPAA Privacy Practices for Protected Health Information
and / or
I have been given the opportunity to review in this Chiropractic Office the
Notice of HIPAA Privacy Practices for Protected Health Information

Patient Name (PRINT) _____

Patient (SIGN) _____

Date _____

CONSENT TO TREAT A MINOR

Minor's Name (PRINT) _____

Parent/Guardian Authorizing Care (PRINT) _____

Parent/Guardian Authorizing Care (SIGN) _____

Date _____

WITNESS SIGNATURE

Witness Name (PRINT) _____

Witness (SIGN) _____

Date _____