Patient Health Survey

INLINE CHIROPRACTIC

About You

Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Home Phone: | | | | | | | | | | |

Cell Phone: | | | | | | | | | | |

Email Address: _____

Date of Birth: | | | | | | | | | Age: _____

Social Security Number: | | | | | | | | | |

Gender: _____ Number of Children: _____ Marital Status ◯ Divorced ◯ Married ◯ Single ◯ Widowed

Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____

Employer Zip Code: _____ Work Phone: | | | | | | | | | | |

Position/Title: _____

How Did You Hear About Us

Who referred you to our office? _____

Have you seen or heard of our office because of (check all that apply):

☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing

Have you been treated by a chiropractor before?

◯ Yes ◯ No

If yes, what was the reason for the visit? _____

Approximate date of last visit? _____

Health Habits

Do you smoke? ◯ Yes ◯ No

Do you drink alcohol? ◯ Yes ◯ No

Do you drink coffee, tea or soda? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you wear? ◯ Heel lifts ◯ Sole lifts ◯ Inner soles ◯ Arch supports

Reason For This Visit

Describe the reason for this visit: _____

Is the purpose of this appointment related to:

◯ Job ◯ Sports ◯ Auto ◯ Fall ◯ Home Injury ◯ Chronic Discomfort ◯ Other

Please explain: _____

If job related, have you made a report of your accident to your employer? ◯ Yes ◯ No

When did this condition begin? _____ Has this condition: ◯ Gotten worse ◯ Stayed constant ◯ Come and gone

Does this condition interfere with? ☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

Please explain: _____

Has this condition occurred before? ◯ Yes ◯ No Please explain: _____

Have you seen other doctors for this condition? ◯ Yes ◯ No Doctors Name: _____

Type of treatment: _____ Results: _____

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Patient # _____ Height _____ Weight _____

Full Name _____ Age _____ Date _____

Have you ever (at any time) experienced any of the following?

Difficulty urinating	◯ Y	◯ N	Claustrophobia (fear of small spaces)	◯ Y	◯ N
Loss of bladder control	◯ Y	◯ N	Spinal surgery	◯ Y	◯ N
Loss of bowel control	◯ Y	◯ N	Common cold/flu	◯ Y	◯ N
Temporary loss of vision, one eye	◯ Y	◯ N	Carotid artery surgery	◯ Y	◯ N
Blood in urine	◯ Y	◯ N	Breast removal	◯ Y	◯ N

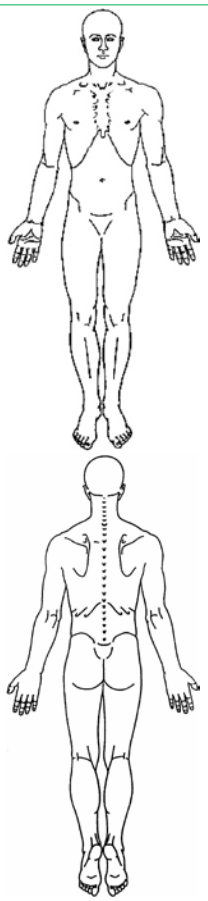
Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	◯ N	◯	Rheumatoid arthritis	Y	◯ N	◯
Stroke	Y	◯ N	◯	Fractured/broken vertebra	Y	◯ N	◯
Slipped disc	Y	◯ N	◯	Bleeding disorders	Y	◯ N	◯
Herniated disc	Y	◯ N	◯	High blood pressure	Y	◯ N	◯
Osteoporosis	Y	◯ N	◯	Blood in stool	Y	◯ N	◯
TIA's (pin or mini strokes)	Y	◯ N	◯	Cancer	Y	◯ N	◯
Drop attacks (collapsing, but not	Y	◯ N	◯	AIDS	Y	◯ N	◯
Hardening of the arteries	Y	◯ N	◯	Kidney disease	Y	◯ N	◯
Partial or complete paralysis	Y	◯ N	◯	Prostate disease	Y	◯ N	◯

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	◯ Y	◯ N	Memory loss	◯ Y	◯ N
Vomiting	◯ Y	◯ N	Fever	◯ Y	◯ N
Vertigo (spinning)	◯ Y	◯ N	Recurrent headaches	◯ Y	◯ N
Difficulty walking	◯ Y	◯ N	Diarrhea	◯ Y	◯ N
Incoordination	◯ Y	◯ N	Skin rash/infection	◯ Y	◯ N
Loss of consciousness	◯ Y	◯ N	A major fall	◯ Y	◯ N
Double vision	◯ Y	◯ N	A minor fall	◯ Y	◯ N
Blurred vision	◯ Y	◯ N	An auto accident	◯ Y	◯ N
Speech problems	◯ Y	◯ N	A work injury	◯ Y	◯ N
Clumsiness	◯ Y	◯ N	Head trauma	◯ Y	◯ N
Loss of strength	◯ Y	◯ N	Tinnitus (ringing in ears)	◯ Y	◯ N
Abnormal menstruation	◯ Y	◯ N	Painful bowel movements	◯ Y	◯ N

Numbness or other sensory complaints ◯ Y ◯ N



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Medication You Take

Medications:

Medication Allergies:

Health Conditions

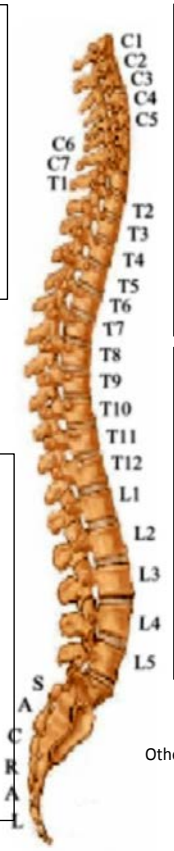
Instructions: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect your customized care plan and the possibility of being accepted for care.

- ☐ Severe or Frequent Headaches
- ☐ Heart Surgery/Pacemaker
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Pain between Shoulders
- ☐ Congenital Heart Defect
- ☐ Frequent Neck Pain
- ☐ Thyroid Problems
- ☐ Sinus Problems
- ☐ Hepatitis
- ☐ Difficulty Breathing
- ☐ Kidney Problems
- ☐ Dizziness
- ☐ Chemotherapy
- ☐ Rheumatic Fever
- ☐ Ulcers/Colitis
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Shingles
- ☐ Numbness
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Surgeries
- ☐ Asthma
- ☐ Loss of Sleep
- ☐ Depression/Anxiety
- ☐ Pain in Arms/Legs/Hands
- ☐ Low Blood Pressure

Your Concerns

Instructions: Please check box for only the health concerns or conditions you may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function.

- ☐ Sore throat
- ☐ Stiff neck
- ☐ Radiating arm pain
- ☐ Hand/finger numbness
- ☐ Asthma
- ☐ Allergies
- ☐ Heart condition
- ☐ High blood pressure



- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Sinus problems
- ☐ Allergies
- ☐ Fatigue
- ☐ Head colds
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Difficulty Concentrating

- ☐ Middle back pain
- ☐ Congestion
- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Gallbladder condition
- ☐ Stomach problems
- ☐ Ulcers
- ☐ Gastritis
- ☐ Kidney problems

- ☐ Constipation
- ☐ Colitis
- ☐ Diarrhea
- ☐ Gas Pain
- ☐ Irritable bowel
- ☐ Bladder Problems
- ☐ Menstrual problems
- ☐ Low back pain
- ☐ Leg pain or numbness
- ☐ Reproductive problems

Other:

Health Conditions - For Women Only

Are you pregnant? ○ Yes ○ No

If yes, when is your due date? _____

Are you nursing? ○ Yes ○ No

Are you taking birth control? ○ Yes ○ No

Family History

☐ Diabetes
Relationship:_____ Outcome:_____

☐ High Blood Pressure
Relationship:_____ Outcome:_____

☐ Cancer
Relationship:_____ Outcome:_____

☐ Heart Failure
Relationship:_____ Outcome:_____

☐ Kidney Disease
Relationship:_____ Outcome:_____

☐ Stroke
Relationship:_____ Outcome:_____

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Please check one:

Race: ☐ Caucasian ☐ Asian or Pacific Islander ☐ African American ☐ Hispanic ☐ Native American or Alaskan Native

Ethnicity: ☐ Non-Latino ☐ Latino

Primary Language: _____

Smoking history: Please check: ☐ Never ☐ Quit - number years smoking _____ ☐ # cigs per day

☐ Current smoker: number years smoking ☐ # cigs per day

Allergies: _____

Blood Pressure: _____ Has any doctor diagnosed you with Hypertension presently? ◯ Yes ◯ No

If Yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ◯ Yes ◯ No If yes, what kind? ☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 8.0%

If you know your Hemoglobin A1c, please write it in: _____

Have you had an X-Ray or CT scan or MRI of your low back or spine within the past 28 days? ◯ Yes ◯ No

Communication Authorization

May we leave appointment information or messages with the person that answers the phone? ◯ Yes ◯ No

May we leave appointment information or messages on your answering machine? ◯ Yes ◯ No

May we send appointment information or messages to your email address? ◯ Yes ◯ No

May we text appointment reminders/information to your cell phone? ◯ Yes ◯ No

May we send mailers regarding appointment reminders, birthday cards, health related products, new services provided and/or newsletters? Yes No

Contact

With whom may we discuss your medical condition/billing questions and/or your child's medical condition/billing information/ questions other than yourself?

1. _____ Phone # _____

2. _____ Phone # _____

Signature _____ Date: _____

IN CASE OF AN EMERGENCY, CONTACT:

Name _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____