Health History Form

Name: _____DOB: _____Age_____Height: _____ Weight: _____

Home Phone #: _____Cell Phone #:_____Work Phone #: _____

Address: _____City: _____ State _____Zip: _____

E-mail Address: _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Employer: _____

Emergency Contact _____ Relation_____ Phone # _____

How did you hear about our office? ☐ Drive by ☐ Lawyer ☐ Provider Referral ☐ Health Magazine

☐ Marketing Event _____ ☐ Existing Patient _____ ☐ Other_____

INSURANCE INFORMATION:

Personal Injury Insurance Company Name: _____ Claim #: _____

Adjustor's Name: _____ Adjustor's Phone number: _____

Do you have health insurance as a secondary insurance? ☐ Yes ☐ No

Insurance Name: _____ Member Id: _____

Phone #: _____ Policy Holder Name: _____ DOB: _____

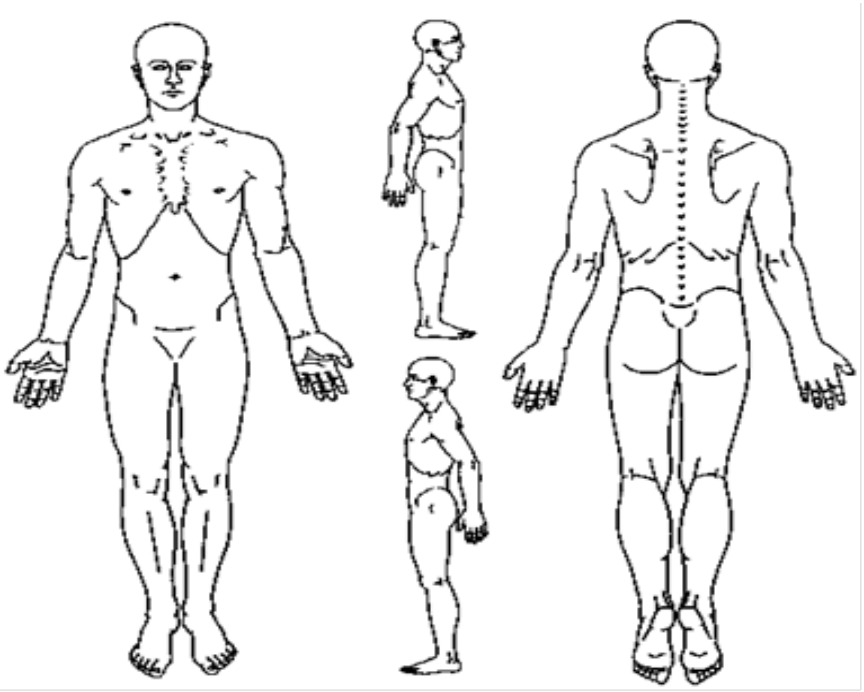
Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Effective Chiropractic Inc., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.) I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits, I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient/Responsible Party Print: _____ Patient/Responsible Party Signature: _____

Date: _____

CHECK AREAS OF PAIN OR DISCOMFORT FOR ALL COMPLAINT(S):



RATE LEVEL OF DISCOMFORT ON A SCALE OF 1-10 (10 BEING WORST PAIN)

NECK PAIN : ☐**None** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐100% ☐90% ☐80% ☐70% ☐60% ☐50% ☐40% ☐30% ☐20% ☐10%
What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____

SHOULDER/ARM PAIN: ☐**None** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐100% ☐90% ☐80% ☐70% ☐60% ☐50% ☐40% ☐30% ☐20% ☐10%
What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____

MID BACK PAIN: ☐**None** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐100% ☐90% ☐80% ☐70% ☐60% ☐50% ☐40% ☐30% ☐20% ☐10%
What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____

LOW BACK PAIN: ☐**None** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐100% ☐90% ☐80% ☐70% ☐60% ☐50% ☐40% ☐30% ☐20% ☐10%
What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____

HIP/LEG PAIN (RIGHT OR LEFT): ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐100% ☐90% ☐80% ☐70% ☐60% ☐50% ☐40% ☐30% ☐20% ☐10%
What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____

HEADACHE PAIN: ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____

OTHER PAIN: _____ ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Svere**

Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%

What does the pain feel like? ☐Achy ☐ Burning ☐Crushing ☐ Dull ☐Numb ☐ Sharp ☐Shooting ☐Stiff ☐Tingling

Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____

When did the pain start? _____ _____

What makes the pain worse?

☐Bending ☐Cleaning ☐ Cooking ☐coughing ☐ dressing ☐driving ☐exercising ☐ kneeling ☐ lifting ☐lying ☐ reaching

☐pulling ☐pushing ☐ running ☐sitting ☐standing ☐sneezing☐ turning ☐typing ☐walking ☐working Other _____

What makes the pain better? ☐Resting ☐Sitting ☐Stretching ☐Therapy ☐Pain medication ☐Nothing other: _____

My pain is☐Constant ☐ Intermittent☐Worse in AM☐Worse in PM

How does the pain affect your life? ☐Lose patience with spouse/children ☐Restricted household duties ☐Hinders ability to exercise ☐Restricted in your daily activities ☐ Interferes with work ☐ Interrupts sleep

What type of work do you do? _____ List job requirements: _____

Have you lost any days of work from this injury?☐ Yes ☐No **If yes, give dates: _____**

SYMPTOMS: Please check if you have experienced any of the following symptoms in the past 6 months

☐ Tired/Fatigued ☐ Difficulty talking☐ Difficulty Sleeping

☐ Ringing in Ears ☐ Dizziness ☐ Vomiting

☐ Unclear Thinking ☐ Nausea☐ Changes in Vision

☐ Difficulty swallowing ☐ Difficulty withbalance ☐ Other: _____

PREVIOUS ACCIDENT HISTORY*:*

Have you been involved in vehicle accidents? ☐ Yes ☐ No

Please describe and give dates:_____

When was your last treatment for injuries related to that accident? _____

SOCIAL HISTORY

What is your daily/weekly intake of the following?

Caffeine _____cups/dayAlcohol _____drinks/weekCigarettes _____pack(s)day

Exercise: ☐ Frequently ☐ Moderately☐ Occasionally ☐ None

MEDICAL HISTORY

Please check if you have currently or have any of the following conditions

☐ **NONE**

☐ ADD/ADHD	☐ CHEMICAL DEPENDENCY	☐ HIGH CHOLESTEROL	☐ PROSTATE PROBLEMS
☐ AIDS/HIV	☐ CHICKEN POX	☐ HORMONE PROBLEMS	☐ PROSTHESIS
☐ ALCOHOLISM	☐ COLON TROUBLE	☐ INSOMNIA	☐ PSYCHIATRIC CARE
☐ ALLERGY SHOTS	☐ DIABETES	☐ KIDNEY PROBLEMS	☐ RHEUMATOID ARTHRITIS
☐ ANEMIA	☐ EAR INFECTIONS	☐ LIVER DISEASE	☐ SEXUAL DIFFICULTY
☐ ANOREXIA	☐ EPILEPSY	☐ MEASLES	☐ STROKE
☐ APPENDICITIS	☐ GALL BLADDER PROBLEMS	☐ MENOPAUSAL PROBLEMS	☐ SUICIDE ATTEMPT
☐ ARTHRITIS	☐ GLAUCOMA	☐ MIGRAINES	☐ THYROID PROBLEMS
☐ ASTHMA	☐ GOUT	☐ MISCARRIAGE	☐ TMJ PAIN
☐ BLEEDING DISORDER	☐ HEART ATTACK	☐ MULTIPLE SCLEROSIS	☐ TONSILLITIS
☐ BLOOD PRESSURE (HIGH OR LOW)	☐ HEART PROBLEMS	☐ MUMPS	☐ TREMORS
☐ BREAST LUMP	☐ HEMORRHOIDS	☐ OSTEOPOROSIS	☐ TUBERCULOSIS
☐ BROKEN BONES	☐ HEPATITIS	☐ PACEMAKER	☐ TUMORS/GROWTHS
☐ BRONCHITIS	☐ HERNIA	☐ PARKINSON'S DISEASE	☐ TYPHOID FEVER
☐ BULIMIA	☐ HERNIATED DISC	☐ PNEUMONIA	☐ ULCERS
☐ CANCER	☐ HERPES	☐ POLIO	☐ VENERAL DISEASE
☐ CATARACTS			☐ OTHER_____

ALLERGIES:
Check any known allergy you have

- ☐ **NONE**
- ☐ MILK
- ☐ EGGS
- ☐ PEANUTS
- ☐ ALMONDS
- ☐ CASHEWS
- ☐ WALNUTS
- ☐ FISH
- ☐ SHELLFISH
- ☐ SOY
- ☐ WHEAT
- ☐ GLUTEN
- ☐ PENICILLIN
- ☐ SULFA DRUGS
- ☐ TETRACYCLINE
- ☐ PHENYTOIN
- ☐ CARBAMAZEPINE
- ☐ CODEINE
- ☐ NSAIDS
- ☐ MOLD
- ☐ DUST
- ☐ FUNGUS
- ☐ MITES
- ☐ TREE POLLEN
- ☐ WEED POLLEN
- ☐ DOG DANDER
- ☐ CAT DANDER
- ☐ LATEX
- ☐ OTHER: _____

Are you currently under medical care for any condition? ☐Yes ☐ No
If yes, explain: _____

Please list any and all medications you are currently taking:

_____

Please list any surgeries and/or hospitalization you have had (type & date):

_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):

_____

FAMILY HISTORY

Is there a family history of any of the following conditions?
Heart Disease_____ Diabetes _____Cancer: _____ Arthritis: _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health, I will give complete and accurate information during my exam.

Print Name: _____

Signature: _____ Date: _____

X-ray Questionnaire: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are **not** pregnant at this time.

- ☐ There is a possibility that I may be pregnant at this time
- ☐ Yes, I am definitely pregnant
- ☐ No, I am definitely not pregnant at this time
- ☐ I request that x-ray films not be taken because

_____

Date of last menstrual period: _____

Patient Signature: _____ Date: _____

FOR PROVIDER USE ONLY

C: F E RLF LLF LRO ROT

L: F E RLF LLF LRO ROT

DTR: C5 C6 C7 L4 S1

SENSORY:C5 C6 C7 L4 S1

STRENGTH: C5 C6 C7 L4 L5-S1

Comp Distract Max-X Soto Depressor

SLR Kemps MilgramsSicards