

Confidential Patient History

Patient Information: Please print and answer all questions.

Name (Last, First, MI.) _____ Phone: _____

Address: _____

City, State, Zip: _____

Birth Date: _____ Sex: ___M___F SSN: _____

Driver's License #: _____

Circle One: Married Single Divorced Widowed Children & Ages: _____

Employer: _____ Work Phone: _____

Spouse SSN: _____

E-mail Address: _____

Emergency Contact Name, Phone, and Relationship: _____

How did you hear of our office? _____

You Deserve to be Healthy. Life is a miracle and so are you. When you were created, you were given all the Blue-prints, Intelligence, Tools, and Systems to live an Active Healthy Life. Unfortunately, your health can be interfered with through accidents, falls, sports injuries and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in Chiropractic care, we will work to REMOVE these interferences to your natural health expression, so that you can live the quality of life you DESERVE!

Current Health Condition:

Purpose of this appointment: _____

Is this condition: ___Auto Accident ___Job Related ___Sports Injury ___Chronic ___Other: _____

Family Doctor Name: _____ May we contact your family doctor if necessary? ___Yes ___No

Medications or Supplements Taken? _____

Previous Chiropractic Care: ___None ___Doctor's name and last visit: _____

Why Chiropractic?

People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so that Dr. Lee may be guided by your wishes whenever possible.

Stage 1 ___Pain relief: Just get rid of the pain, Doc! Relief is short-term.

Stage 2 ___Corrective: Get rid of the pain, Doc, but then fix this problem so that it doesn't come back!

Stage 3 ___Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible throughout my life.

Patient Name: _____

Check Your Symptoms (Scale 1 to 10—10 being High)

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Back Pain / Stiffness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain/ Stiffness | <input type="checkbox"/> Hip Pain / Stiffness (R or L) | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Leg Tingling / Numbness (R or L) | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Buzzing or Ringing in Ears | <input type="checkbox"/> Knee Pain / Stiffness (R or L) | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Shoulder Pain / Stiffness (R or L) | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Arm Pain/Tingling/Numbness (R or L) | <input type="checkbox"/> Muscle Spasms / Soreness | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Elbow Pain / Stiffness | <input type="checkbox"/> Tension / Irritability | <input type="checkbox"/> Asthma / Allergies |
| <input type="checkbox"/> Wrist Pain / Stiffness (R or L) | <input type="checkbox"/> Depression / Crying Spells | <input type="checkbox"/> High BP |
| <input type="checkbox"/> Hand Pain/Tingling/Numbness (R or L) | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Low BP |
| <input type="checkbox"/> Mid Back Pain / Stiffness | <input type="checkbox"/> Difficulty Sleeping | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Breathing | |

Social History:

What are your favorite hobbies or activities to do now? _____

Are your current problems affecting these activities or hobbies?: Yes No

What activities are you looking forward to doing in retirement?: _____

Are you on any special diets? Yes No Is so, describe: _____

Are you currently wearing: Heel Lifts Arch Supports

Do you smoke? Yes No If Yes, indicate number of packs per day: Under 1 1 2 3 or more

Do you exercise? Yes No If Yes, describe: _____

Do you drink: Coffee Tea Alcoholic beverages Soda If checked, how often _____

Evaluate the stress you get:

From your occupation: Severe/Constant Moderate Minimal None

From your family: Severe/Constant Moderate Minimal None

From your financial situation: Severe/Constant Moderate Minimal None

Family History: (please check those diseases that have affected you (X) or your family (O):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV pos (AIDS) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Retardation | <input type="checkbox"/> Circulatory Problem |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Overweight/Obesity | <input type="checkbox"/> Other _____ |

List all previous illnesses, injuries and hospitalizations / operations:

Area of body/ Symptoms	Date	Describe (include any medication)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____

Systems Review

Please indicate with a (C) **Conditions you have now** or with a (P) the conditions you have had **In the Past**. If neither apply, please mark (NA), please don't leave any blanks.

- | | | |
|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness/ Fainting | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Low Resistance | <input type="checkbox"/> Tension | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Eye/Vision Problems |
| <input type="checkbox"/> Ear/Hearing Problems | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Female Problems |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Hand Tremors | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Sweaty Palms | <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | |

Upon the completion of your first visit, you will be scheduled for a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic report appointment so you can choose the level of participation that supports you in reaching ALL of your health goals.

Financial Policy and Patient Service Agreement:

Who is responsible for your bill? You and: Health Ins. Medicare Auto Ins. Worker's Comp.

Payment is due at the time of service in the form of a deductible, co-payment, or coinsurance payment.

Your policy is a contract between you and the insurance company and you are responsible to Masontown Chiropractic to insure that your insurance company processes the claims pertaining to your treatment in our office.

If your insurance company sends you checks, it is your responsibility to deliver them to our office within 5 (five) days.

Affordable payment plans are available for those who do not have third party insurance coverage.

I certify this information to be true and correct. I assign my benefits payments to be paid directly to Masontown Chiropractic; however I understand that I am ultimately responsible for payment of services rendered. I also authorize the release of any information which is required. Furthermore, I understand that Masontown Chiropractic is not claiming to be a cure-all for my symptoms, and there are no guarantees.

Upon seeing the doctor, I have read and signed the Notice of Privacy Practices For Protected Health Information and the Health Care Authorization Form and have accepted these policies.

Patient or Guardian Signature

____/____/_____
Date

Witness

Date: _____

Patient: _____

Masontown Chiropractic Patient History

1. What is your **main complaint**? _____

2. On the scale below, please circle the **severity** of your **main complaint** (at it's worst)

None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

3. On the scale below, please circle the **percentage of time** you experience your **main complaint**:

Occasional			Intermittent				Constant			
0%	10	20	30	40	50	60	70	80	90	100%

4. How long have you been experiencing your main complaint? _____

5. What caused your main complaint? _____

6. When do you notice it most? A.M. _____ or P.M. _____ How long does it last? Min _____ Hrs _____

7. What makes it feel better? _____

8. What makes it feel worst? _____

9. Have you ever had this problem in the past? Yes ___ No ___

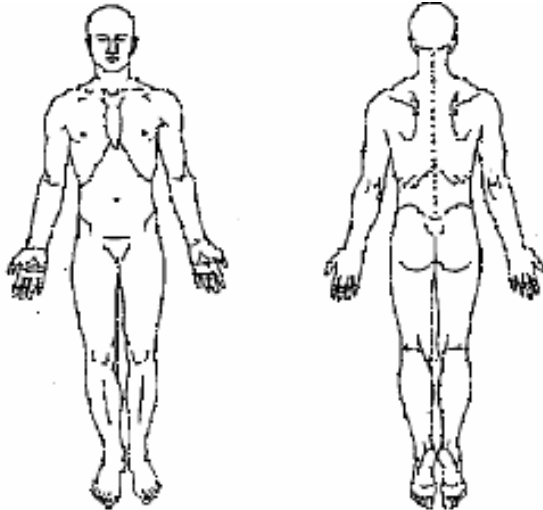
10. I have: Been hospitalized ___ Been treated by another Chiropractor _____

Been treated by another specialty provider ___ Never received care for this problem ___

11. Have you lost time from work because of it? Yes ___ No ___ Dates? _____ to _____

12. Are you pregnant? Yes ___ No ___ When was your last menstrual cycle? _____

- Ache
- Spasm
- Tenderness
- Burning
- Stabbing
- Pain
- Sharp
- Dull
- Stiffness
- Constant
- Comes & Goes
- Tingling
- Numbness



On the above diagram, please **mark** where you are experiencing **all** of your present complaints.

Do you have pain and / or difficulty performing any of the following activities: (Check)

- Personal care _____
- Lifting _____
- Reading _____
- Concentrating _____
- Work _____
- Driving _____
- Sleeping _____
- Recreation _____
- Walking _____
- Sitting _____
- Standing _____
- Social Life _____

Signature: _____

Date: _____