Date:

HEALTH HISTORY QUESTIONNAIRE

Name *(First, M.I, Last):* ☐ M ☐ F **DOB:** **Age:**			
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Address:	**City, State, Zip:**		
Home Phone: ( ) -	**Cell Phone: ( ) -**	**Cell Carrier:**	☐ Texting is acceptable
Email Address:	**Preferred Contact Number:** ☐ Home ☐ Cell		
Emergency Contact:	**Phone Number: ( ) -**	**Relationship:**	
Previous or referring doctor:	**Date of last physical exam:**		
How did you hear about us?			

EMPLOYER

Business Name:	**Occupation/Job Title:**
Work Phone: ( ) -	
Repetitive Activities: ☐**Computer** ☐**Phone** ☐**Machinery** ☐**Hand Tools** ☐**Assembly** ☐**Grasping** ☐**Heavy Lifting**	

PAYMENT

Who is responsible for your bill? ☐ **Self/Non-Insurance** ☐ **Please verify my insurance benefits** ***(Provide insurance card)***		
Insurance Holder:	**Holder's DOB:**	**Relationship to patient:**

PERSONAL HEALTH HISTORY

Childhood Illnesses:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and Dates:	☐ Tetanus	☐ Pneumonia		
	☐ Hepatitis	☐ Chickenpox		
	☐ Influenza *(Flu Shot)*	☐ Other		
Medical Conditions:	☐ Diabetes Type ____	☐ Heart Disease_____	☐ Cancer (Type_____)	
	☐ Hypertension	☐ Lupus	☐ Fibromyalgia	☐ CVA (Stroke)
	☐ Other:			
Surgeries and Dates:	☐ Joint Replacement	☐ Joint Reconstruction	☐ Spinal Fusion	
	☐ Laminectomy	☐ Rotator Cuff		
	☐ Other:			
	Year	Surgery	Year	Surgery
Injuries and Dates:	☐ Broken Bones	☐ Severe Fall	☐ Joint Injury	
	☐ Head Injury	☐ Back Injury	☐ Car Accident	
	☐ Other:			

Do you wear any of the following: ☐ Heel lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics

MEDICATIONS

List your prescribed drugs and over-the-counter drugs. (Attached list is preferable if possible.)

Drug Name	Dosage	Frequency Taken

Please list any allergies to medication.

REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

CONSTITUTIONAL	GASTROINTESTINAL	PSYCHOLOGIC
☐ Weight Gain	☐ Nausea	☐ Depression
☐ Weight Loss	☐ Abnormal Stool Consistency	☐ Insomnia
☐ Fatigue	☐ Vomiting	☐ Mood Change(s)
EYES/VISION	**ENDOCRINE**	**SKIN**
☐ Wear glasses and/or contact lenses	☐ Diabetes	☐ Rash
☐ Change in vision	☐ Cold Intolerance	☐ Hair Loss
☐ Double vision	☐ Excessive Thirst	☐ Paresthesia (numbness, prickling, tingling)
RESPIRATION	**HEMATOLOGY**	**NERVOUS SYSTEM**
☐ Cough	☐ Anemia	☐ Headaches
☐ Shortness of breath	☐ Blood Clotting	☐ Limb Weakness
☐ Asthma	☐ Bruises Easily	☐ Seizures
EARS, NOSE, AND THROAT	**CARDIOVASCULAR**	☐ Numbness
☐ Dizziness	☐ Heart Problems	☐ Memory Loss
☐ Headaches	☐ Chest Pain	**OTHER**
☐ Head Injury (history of)	☐ Palpitations (irregular or forceful heartbeat)	☐
☐ Loss of Smell	☐ Heart Murmor	☐

WOMEN ONLY

I am:	☐ Currently Pregnant	☐ In Menopause	☐ N/A
My menses cycle is:	☐ Regular	☐ Irregular	☐ N/A
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies:			
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?		☐ Yes	☐ No
Do you experience hot flashes or sweating at night?		☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No

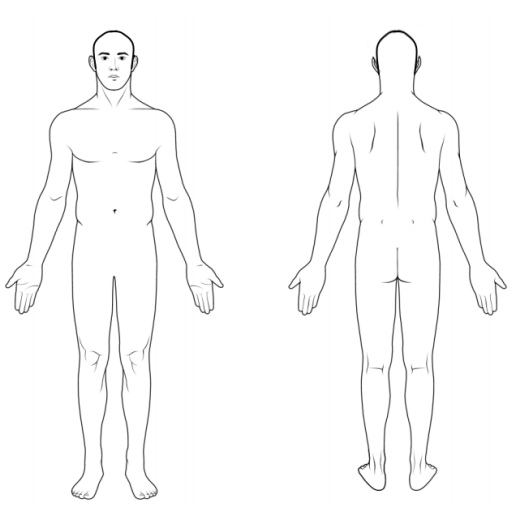
MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (no exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week or more for 30 minutes)					
Diet	Are you eating what you consider a healthy diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?	☐ Occasionally	☐ Often	☐ Social Consumption	☐ Never	
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational drugs?				☐ Yes	☐ No
Personal Safety	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

FAMILY HEALTH HISTORY					
	AGE	**SIGNIFICANT HEALTH HISTORY**		**AGE**	**SIGNIFICANT HEALTH HISTORY**
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

CURRENT CONDITION

Chief Complaint											
Condition	☐ New	☐ Recurring	☐ New Episode	☐ Chronic							
Onset & Date	☐ Auto/Work Accident			☐ Slept Wrong							
	☐ Overexertion/Repetitive Use			☐ Unknown/No Injury							
	☐ Slip/Fall			☐ Other							
Symptoms & Locations	☐ Pain	☐ Numbness	☐ Stiffness								
	☐ Weakness										
	☐ Other:										
Quality	*Please use the designated letters, arrows, and circles to indicate on the diagram the areas of current complaint.*										
	☐ Burning (B)	☐ Dull/Achy (A)									
	☐ Diffuse (D)	☐ Tightness (T)									
	☐ Sharp (S)	☐ Localized (L)									
	☐ Shooting (Sh)	☐ Tingling (Ti)									
	☐ Stabbing (St)	☐ Throbbing (Th)									
	☐ Other:										
	☐ Additional Notes:										
	Does the pain radiate or travel to another location?	☐ No	☐ Yes	If yes, where?							
Associated Symptoms	☐ Blurred Vision	☐ Depression	☐ Dizziness	☐ Irritability/ Mood Swings	☐ Nausea	☐ Ringing in Ears					
	☐ Headaches	Location: ☐ Occipital	☐ Frontal	☐ Temporal	☐ Parietal	☐ Sinus					
		Quality: ☐ Dull	☐ Sharp	☐ Throbbing	☐ Stabbing	☐ Aura	☐ No Aura				
		Type: ☐ Hat Band	☐ Cluster	☐ Migraine	☐ Tension						
	☐ Other:										
Scale 0-10, 10 Being the Worse	How do you rate your discomfort while you are resting?	0	1	2	3	4	5	6	7	8	9	10
	While performing activities?	0	1	2	3	4	5	6	7	8	9	10
Timing & Context	Worse in the:	☐ Morning	☐ Afternoon	☐ Night	☐ With Activity	☐ Constant	☐ Intermittent					
	Better with:	☐ Heat	☐ Cold	☐ Movement	☐ Rest	☐ Meds	☐ Stretching					
History of Condition	Have you seen other doctors for this condition?	☐ No	☐ Yes	If yes, who?								
	Type of treatment?	Outcome of treatment?										
Activities	*Please indicate which activities your current condition affects. Please use the following key to illustrate severity.* N = no effect (not painful) , C = can do activity (painful) , L = limited ability (painful) , U = unable to perform										
	☐ Driving	☐ Carrying	☐ Changing Position	☐ Stairs							
	☐ Care for Family	☐ Computer	☐ Chores	☐ Yard Work							
	☐ Walking	☐ Prolonged Standing	☐ Prolonged Sitting	☐ Self Care							
	☐ Sleep	☐ Lifting	☐ Golf	☐ Swimming							
	☐ Bowling	☐ Tennis	☐ Hiking	☐ Running							
	☐ Other										

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well. Other procedures commonly used by Doctors of Chiropractic include the following:

- physical examination
- ultrasound therapy
- laser therapy
- palpation
- postural analysis
- hot/cold therapy
- traction/decompression
- rehabilitation
- vital signs
- diagnostic studies
- electrical muscle stimulation
- bracing and support applications
- manual therapy
- acupuncture/dry needling

The material risks associated with chiropractic treatment:
Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.
The probability of those risks occurring:
Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.
The availability and nature of other treatment options may include the following:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor. **Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.**
I understand and accept that:
1. I have the right to withdraw from or discontinue treatment at any time and that Complete Chiropractic & Wellness Center will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Complete Chiropractic & Wellness Center does not guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH BELOW AND SIGN.
Patient:
I [ ] have read, or [ ] have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize Complete Chiropractic & Wellness Center to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Complete Chiropractic & Wellness Center and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient's Name Patient's Signature

_____ _____
Date Signature of Parent/Guardian (if patient is a minor)

Medicare Coverage Notice

Medicare covers for Chiropractic Adjustments. Coverage is subject to the Medicare deductible and coinsurance, as well as limitations and exclusions. If you have a secondary, it may cover all or part of your deductible and coinsurance.

However, Medicare does not cover for other services at our office.
Services not covered by Medicare include:

- Exams and Re-Exams
- X-Rays
- Manual/Massage Therapy
- Interferential
- Mechanical Traction
- Low Level Laser Therapy
- Maintenance Care

The cost for these services are the patient's responsibility and are due at the time of service.

By signing below, you agree that you have read and understand the above.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date