

Patient Information

GENERAL INFO	Today's Date: _____
	Patient's First Name: _____ Middle Initial: _____ Last Name: _____
	What Do You Prefer to be Called: _____ Address: _____
	City: _____ State: _____ Zip Code: _____
	Home Phone: _____ Cell Phone: _____
	Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____
	E-mail Address: _____
Work/Student Status: <input type="checkbox"/> Employed <input type="checkbox"/> F/T Student <input type="checkbox"/> P/T Student <input type="checkbox"/> Other _____	
<i>If student over 18, please indicate name of school for insurance purposes: _____</i>	

FAMILY	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other Is your spouse a patient at HealthZone Chiropractic? Yes / No
	Spouse's First Name: _____ Middle Initial: _____ Last Name: _____
	Date of Birth: _____ Social Security Number: _____
	Cell Phone: _____ Work Phone: _____
Number of Children: _____ Names/Ages: _____	

WORK	Employer Name: _____
	Work Phone: _____ Is it ok to call you at work? Yes / No
	Address: _____
	City: _____ State: _____ Zip Code: _____

INSURANCE	Insurance Co: _____ Phone: _____
	Policy Holder's Name: _____
	Policy Holder's Date of Birth _____ Relationship to Patient: _____
	Policy/Member #: _____ Group #: _____
	Assignment and Release of Benefits: I, the undersigned, certify that if I have insurance coverage, I assign directly to HealthZone Chiropractic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions: Responsible Party Signature: _____ Date: _____

Emergency Contact (other than parent): _____ Phone: _____
Relationship to the patient: _____

Whom may we thank for referring you? Name: _____
<input type="checkbox"/> Friend <input type="checkbox"/> Family Member <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Other: _____

Health Questionnaire

HISTORY OF PRESENT ILLNESS

Present Complaint:

Describe ALL present health complaints: _____

When did your complaints begin? _____

How did they begin? _____

Was there an accident or injury involved? Yes / No if yes, have you reported your injury? Yes / No

Have you experienced symptoms like this in the past (this is not your first time dealing with similar symptoms)? Y / N

Yes / No If yes, how long ago? _____

Does the pain radiate anywhere? Y / N if yes, where _____

Do you have symptoms anywhere else in your body related to these complaints? Y / N Where? _____

How often do you experience your reported complaints?

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

What describes the nature of your symptoms?

- Sharp Dull Ache Numb Shooting Burning Tingling Other

During the past 4 weeks, indicate the average intensity of your symptoms:

None — 0 1 2 3 4 5 6 7 8 9 10 — Unbearable

What relieves your symptoms (standing, sitting, sleeping, etc)? _____

What makes your symptoms worse? _____

How are your health conditions changing?

- Getting Better Not Changing Getting Worse

Have you noticed any changes in bodily functions (digestion, urination, etc) due to your symptoms? Y / N

If yes, what changes? _____

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

- All of the time Most of the time Some of the time A little of the time None of the time

What activities are you unable to enjoy? _____

Whom have you seen for your complaints prior to coming here?

- No one Other Chiropractor Med. Doctor Phys Therapist Other

What treatment did you receive for your symptoms?

- Adjustments Phys Therapy Medication Surgery Other

When did you receive this treatment?

- In the last month 2-3 months ago 3-6 months ago 6 months — 1 year ago
 1-2 years ago 2-5 years ago 5-10 years ago

In general, how would you describe your overall health right now?

- Excellent Very Good Good Fair Poor

What medications have you taken for the symptoms list above (please indicate how long)?

Health History

MEDICAL HISTORY

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you :

- Drink Alcohol: Yes / No If yes, how often / much? _____
- Drink Coffee / Tea: Yes / No If yes, how often / much? _____
- Drink Water: Yes / No If yes, how often / much? _____
- Smoke / Chew Tobacco: Yes / No If yes, how often / much? _____

How regularly do you exercise: Daily 3-4x/wk 1-2x/wk Less that 1x/wk Never

What type of exercise do you do? _____

On average, how many hours of sleep do you get per night?

< 4 hours 5-6 hours 6-7 hours 8-9 hours > 10 hours

On a scale of 1 (none) to 10 (extreme), please rate you stress level:

- Occupational Stress: _____
- Personal Stress: _____

On a scale of 1 (very poor) to 10 (excellent), please rate your:

- Eating Habits/Quality: _____
- Mental/Emotional Health: _____
- Exercise Habits: _____
- Sleeping Habits/Quality: _____

On average how much time is spent watching TV or in front of the computer?

<30 min/day 30 — 60 min/day >60 min/day

Using the following key, please tell us if anyone in your family has or is currently dealing with any of the following:

M = Mother **F** = Father **B** = Brother **S** = Sister **H** = Husband **W** = Wife **C** = Child

___ Allergies ___ Asthma ___ Psychiatric ___ Thyroid ___ Heart Disease ___ High Cholesterol

___ Diabetes ___ Alzheimer's ___ Arthritis ___ Stroke ___ High Blood Pressure

What allergies do you have? _____

Please list all medications you are currently taking, and why: _____

Please list all surgeries and when they were performed: _____

What do you do to keep yourself healthy? _____

Are you healthier today than you were 5 years ago? Yes No Not Sure

If so, what do you do to stay healthy? _____

If not, why do you think your health declined? _____

What goals do you have for your health? _____

Detailed Review of Systems

Please check (✓) all symptoms you've dealt with in the past or are currently dealing with, whether or not they seem to relate to your current condition.

Cardiovascular:

<input type="checkbox"/> N / A	Present / Past
Poor Circulation	<input type="checkbox"/> / <input type="checkbox"/>
High Bld. Press.	<input type="checkbox"/> / <input type="checkbox"/>
Aortic Aneurysm	<input type="checkbox"/> / <input type="checkbox"/>
Heart Disease	<input type="checkbox"/> / <input type="checkbox"/>
Vascular Disease	<input type="checkbox"/> / <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> / <input type="checkbox"/>
Chest Pain	<input type="checkbox"/> / <input type="checkbox"/>
High Cholesterol	<input type="checkbox"/> / <input type="checkbox"/>
Pace Maker	<input type="checkbox"/> / <input type="checkbox"/>
Jaw Pain	<input type="checkbox"/> / <input type="checkbox"/>
Irreg. Heartbeat	<input type="checkbox"/> / <input type="checkbox"/>
Swelling of Legs	<input type="checkbox"/> / <input type="checkbox"/>
Stroke	<input type="checkbox"/> / <input type="checkbox"/>

Genitourinary:

<input type="checkbox"/> N / A	Present / Past
Kidney Disease	<input type="checkbox"/> / <input type="checkbox"/>
Lower Side Pain	<input type="checkbox"/> / <input type="checkbox"/>
Burning Urination	<input type="checkbox"/> / <input type="checkbox"/>
Freq. Urination	<input type="checkbox"/> / <input type="checkbox"/>
Blood in Urine	<input type="checkbox"/> / <input type="checkbox"/>
Kidney Stone	<input type="checkbox"/> / <input type="checkbox"/>
Bed Wetting	<input type="checkbox"/> / <input type="checkbox"/>
Prostate Prob.	<input type="checkbox"/> / <input type="checkbox"/>

Respiratory:

<input type="checkbox"/> N / A	Present / Past
Asthma	<input type="checkbox"/> / <input type="checkbox"/>
Short of Breath	<input type="checkbox"/> / <input type="checkbox"/>
Cold / Flu	<input type="checkbox"/> / <input type="checkbox"/>
Pneumonia	<input type="checkbox"/> / <input type="checkbox"/>
Cough/Wheeze	<input type="checkbox"/> / <input type="checkbox"/>
Upper Resp. Infec.	<input type="checkbox"/> / <input type="checkbox"/>
Emphysema	<input type="checkbox"/> / <input type="checkbox"/>
RSV	<input type="checkbox"/> / <input type="checkbox"/>
Tuberculosis	<input type="checkbox"/> / <input type="checkbox"/>

Ear/Nose/Throat:

<input type="checkbox"/> N / A	Present / Past
Sinus Congestion	<input type="checkbox"/> / <input type="checkbox"/>
Sinus Infection	<input type="checkbox"/> / <input type="checkbox"/>
Nosebleed	<input type="checkbox"/> / <input type="checkbox"/>
Sore Throat	<input type="checkbox"/> / <input type="checkbox"/>
Diff. Swallowing	<input type="checkbox"/> / <input type="checkbox"/>
Ear Ache	<input type="checkbox"/> / <input type="checkbox"/>
Ear Infection	<input type="checkbox"/> / <input type="checkbox"/>
Dizziness	<input type="checkbox"/> / <input type="checkbox"/>
Hearing Loss	<input type="checkbox"/> / <input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/> / <input type="checkbox"/>

Eyes:

<input type="checkbox"/> N / A	Present / Past
Glaucoma	<input type="checkbox"/> / <input type="checkbox"/>
Double Vision	<input type="checkbox"/> / <input type="checkbox"/>
Blurred Vision	<input type="checkbox"/> / <input type="checkbox"/>
Red, Itchy	<input type="checkbox"/> / <input type="checkbox"/>

Allergic/Immunologic:

<input type="checkbox"/> N / A	Present / Past
Autoimmune disord	<input type="checkbox"/> / <input type="checkbox"/>
Chronic Allergy	<input type="checkbox"/> / <input type="checkbox"/>
Seasonal Allergy	<input type="checkbox"/> / <input type="checkbox"/>
Food Allergy	<input type="checkbox"/> / <input type="checkbox"/>
Environ Allergy	<input type="checkbox"/> / <input type="checkbox"/>
Allergy Shots	<input type="checkbox"/> / <input type="checkbox"/>
Cortisone Use	<input type="checkbox"/> / <input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/> / <input type="checkbox"/>
Hives	<input type="checkbox"/> / <input type="checkbox"/>

Musculoskeletal:

<input type="checkbox"/> N / A	Present / Past
Poor Posture	<input type="checkbox"/> / <input type="checkbox"/>
Neck Pain	<input type="checkbox"/> / <input type="checkbox"/>
Back Pain	<input type="checkbox"/> / <input type="checkbox"/>
Arthritis	<input type="checkbox"/> / <input type="checkbox"/>
Rheumatoid Arth.	<input type="checkbox"/> / <input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/> / <input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/> / <input type="checkbox"/>
Osteoporosis	<input type="checkbox"/> / <input type="checkbox"/>
Broken Bones	<input type="checkbox"/> / <input type="checkbox"/>
Joint Replacement	<input type="checkbox"/> / <input type="checkbox"/>
Gout	<input type="checkbox"/> / <input type="checkbox"/>

Integumentary (Skin):

<input type="checkbox"/> N / A	Present / Past
Eczema	<input type="checkbox"/> / <input type="checkbox"/>
Rashes	<input type="checkbox"/> / <input type="checkbox"/>
Psoriasis	<input type="checkbox"/> / <input type="checkbox"/>
Skin Ulcers	<input type="checkbox"/> / <input type="checkbox"/>
Skin Disease	<input type="checkbox"/> / <input type="checkbox"/>

Gastrointestinal:

<input type="checkbox"/> N / A	Present / Past
Acid Reflux	<input type="checkbox"/> / <input type="checkbox"/>
Bowel Problems	<input type="checkbox"/> / <input type="checkbox"/>
Constipation	<input type="checkbox"/> / <input type="checkbox"/>
Upset Stomach	<input type="checkbox"/> / <input type="checkbox"/>
Gas Pains	<input type="checkbox"/> / <input type="checkbox"/>
Ulcers	<input type="checkbox"/> / <input type="checkbox"/>
Gallbladder Prob.	<input type="checkbox"/> / <input type="checkbox"/>
Liver Problems	<input type="checkbox"/> / <input type="checkbox"/>
Diarrhea	<input type="checkbox"/> / <input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/> / <input type="checkbox"/>
Poor Appetite	<input type="checkbox"/> / <input type="checkbox"/>
Bloody Stools	<input type="checkbox"/> / <input type="checkbox"/>

Neurological:

<input type="checkbox"/> N / A	Present / Past
Seizure	<input type="checkbox"/> / <input type="checkbox"/>
Head Injury	<input type="checkbox"/> / <input type="checkbox"/>
Brain Aneurysm	<input type="checkbox"/> / <input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/> / <input type="checkbox"/>
Pinched Nerves	<input type="checkbox"/> / <input type="checkbox"/>
Radiating Pain	<input type="checkbox"/> / <input type="checkbox"/>
Sciatica	<input type="checkbox"/> / <input type="checkbox"/>
Parkinsons	<input type="checkbox"/> / <input type="checkbox"/>
Carpal Tunnel	<input type="checkbox"/> / <input type="checkbox"/>
Balance Problems	<input type="checkbox"/> / <input type="checkbox"/>
Coordination Prob.	<input type="checkbox"/> / <input type="checkbox"/>
ADHD/ADD	<input type="checkbox"/> / <input type="checkbox"/>
Autism/Spectrum	<input type="checkbox"/> / <input type="checkbox"/>
Headaches	<input type="checkbox"/> / <input type="checkbox"/>
Migraines	<input type="checkbox"/> / <input type="checkbox"/>
Vertigo/Dizziness	<input type="checkbox"/> / <input type="checkbox"/>

Endocrine:

<input type="checkbox"/> N / A	Present / Past
Hyperthyroid	<input type="checkbox"/> / <input type="checkbox"/>
Hypothyroid	<input type="checkbox"/> / <input type="checkbox"/>
Type 1 Diabetes	<input type="checkbox"/> / <input type="checkbox"/>
Type 2 Diabetes	<input type="checkbox"/> / <input type="checkbox"/>
Hair Loss	<input type="checkbox"/> / <input type="checkbox"/>
Menopausal	<input type="checkbox"/> / <input type="checkbox"/>
Menstrual Prob.	<input type="checkbox"/> / <input type="checkbox"/>
Hot Flashes	<input type="checkbox"/> / <input type="checkbox"/>
Endometriosis	<input type="checkbox"/> / <input type="checkbox"/>

Psychiatric:

<input type="checkbox"/> N / A	Present / Past
Depression	<input type="checkbox"/> / <input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/> / <input type="checkbox"/>
Unusual Stress	<input type="checkbox"/> / <input type="checkbox"/>
OCD	<input type="checkbox"/> / <input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/> / <input type="checkbox"/>
Seasonal Affective Disorder	<input type="checkbox"/> / <input type="checkbox"/>
Social Anxieties	<input type="checkbox"/> / <input type="checkbox"/>

Constitutional:

<input type="checkbox"/> N / A	Present / Past
Weight Gain/Loss	<input type="checkbox"/> / <input type="checkbox"/>
Low Energy Level	<input type="checkbox"/> / <input type="checkbox"/>
High Energy Level	<input type="checkbox"/> / <input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/> / <input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/> / <input type="checkbox"/>
General Malaise	<input type="checkbox"/> / <input type="checkbox"/>
Compulsive Behavior	<input type="checkbox"/> / <input type="checkbox"/>
Behavior Issues	<input type="checkbox"/> / <input type="checkbox"/>
Learning Disabilities	<input type="checkbox"/> / <input type="checkbox"/>
Speech Delays	<input type="checkbox"/> / <input type="checkbox"/>

Hematologic/Lymphatic:

<input type="checkbox"/> N / A	Present / Past
Hepatitis	<input type="checkbox"/> / <input type="checkbox"/>
Blood Clots	<input type="checkbox"/> / <input type="checkbox"/>
Cancer	<input type="checkbox"/> / <input type="checkbox"/>
Easy Bruising	<input type="checkbox"/> / <input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/> / <input type="checkbox"/>
Fever/Chills/Sweats	<input type="checkbox"/> / <input type="checkbox"/>

DOCTOR'S USE ONLY: I have reviewed the information contained in this form with the patient in its entirety _____