patient health information

stay tuned chiropractic

If you have been involved in an auto accident or a work injury please speak to one of our office assistants before completing this form.

Name: First _____ Last _____ M.I. ____ Date ___/___/____

Birth Date ____/____/_____ Gender ❑ M ❑ F ❑ Single ❑ Married ❑ Divorced ❑ Widow

Address _____ City, State, Zip _____

Phone: Home _____ Mobile _____ Work _____

Mobile Carrier _____ ❑ I give my permission to receive texts to my phone regarding appointments in this office.

Email _____ Occupation _____

Employers Name _____ Employers Address _____

Spouse's Name _____ No. of children & ages _____

Emergency Contact Person _____ Contact Number _____

Briefly describe your main health concern/complaint

_____

_____

When did it start? _____

What caused it? _____

It is getting: worse / better / staying the same ?

Pain Scale *(please circle your rating if you have pain)*

BEST WORST

0 1 2 3 4 5 6 7 8 9 10

Pain is: constant / comes & goes / do not have pain

Does the pain travel? ❑ Yes ❑ No

If so, where does it travel to? _____

What makes it better? _____

What makes it worse? _____

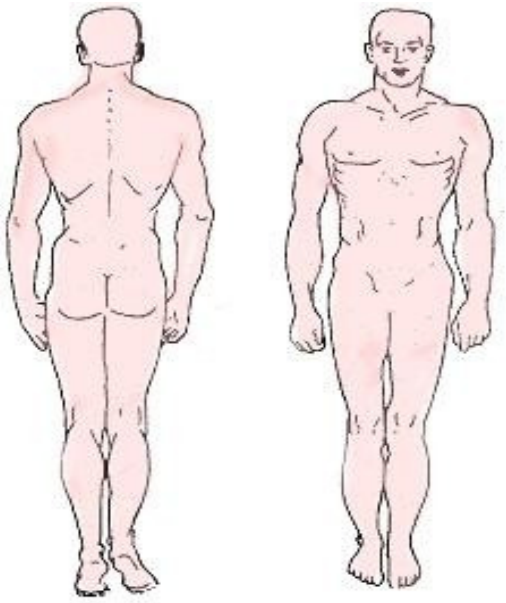
Have you seen any other healthcare providers for this condition? ❑ Y ❑ N Who? _____

Primary Care Dr. _____

Phone # _____

Please check all that describe your current symptoms and mark **X** on the diagram where they occur.

❑ sharp	❑ stiff	❑ aching
❑ stabbing	❑ pinching	❑ numbness
❑ dull	❑ burning	❑ pins/needles
❑ throbbing	❑ tingling	❑ other _____



Have you had this same complaint with similar symptoms in the past? ❑ Y ❑ N

When? _____

FEMALES: Is there a possibility that you are pregnant? ❑ Y ❑ N Have you ever been pregnant before? ❑ Y ❑ N

Please list any other health concerns/complaints you may have now.

In order of severity	Pain Scale 0 – 10	Start date?	Same problem before? Y or N	Caused by Injury? Y or N	Symptoms constant or come & go?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____

Have you been to a chiropractor for any of the above complaints? ❑ Y ❑ N Who? _____

Please indicate ALL issues below that you have now with **C** (C = current problem)
or have had in the past with **P** (P = past problem). If none apply, mark **X** here ❑

__ Arthritis	__ Thyroid	__ Easy Bruising	__ Blood Pressure	__ Food Allergy
__ Back Pain	__ Hearing	__ Psoriasis/Eczema	__ Irreg. Heart Beat	__ Dizziness
__ Sciatic Pain	__ Vision	__ Hives	__ Poor Circulation	__ Infections
__ Headache		__ Skin Allergy		
__ Neck Pain	__ Stomach	__ Itching	__ Kidney	__ HIV
__ Shoulder Pain	__ Intestinal	__ Varicose Veins	__ Diff. Urinating	__ Hepatitis
__ Arm Pain	__ Colon			__ Tuberculosis
__ Wrist Pain		__ Diff. Breathing	__ Menstrual	
__ Hip Pain	__ Liver	__ COPD	__ Pregnancy	__ Hormone
__ Bursitis	__ Gall Bladder	__ Asthma	__ Prostate	__ Brain
__ Foot Pain	__ Pancreas	__ Seasonal Allergy	__ STD	__ Emotional

CIRCLE any of the conditions below you have now or have had in the past, or mark **X** here for none ❑

Stroke / Cancer / Heart Disease / Diabetes / Anemia / Spinal Surgery / Seizures / Spinal Fracture / Scoliosis

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Please list all prescription and non-prescription medications, vitamins and/or herbal supplements you are taking.

1._____ Reason _____ 4. _____ Reason _____

2._____ Reason _____ 5. _____ Reason _____

3._____ Reason _____ 6. _____ Reason _____

Please list any accidents, injuries, surgeries and/or hospitalizations you have had.

1._____ Date _____/_____/_____

2._____ Date _____/_____/_____

On a scale of 0 – 10 (0 = none, 10 = extreme) rate your stress levels:

Personal _____ Home _____ Work _____ School _____

On a scale of 0 – 10 (0 = very poor, 10 = excellent) rate your:

General Health _____ Eating Habits _____ Sleep _____ Exercise _____

List packs/day if you smoke/chew tobacco, glasses/day if you drink alcohol, and any recreational drug use:

_____

Are there any activities at home, work or school that you HAVE NOT been able to do because of the complaint/s that brought you to our office? _____

I _____hereby certify that the information given on this form is accurate to the best of my knowledge and recollection. I agree to allow Dr. Michelle Fox and her designated assistants to perform diagnostic assessments on me in order to achieve the most thorough evaluation of my health as possible, and to determine if I am a candidate for chiropractic care at this time. I have read the Privacy Policy of Stay Tuned Chiropractic, or I am aware that it is available for my viewing.

Signature_____ Date ____/____/_____