Confidential Patient History for Body and Soul Chiropractic

Please complete both sides of this questionnaire.

NAME____DATE__________HOME PHONE_____________

ADDRESS_______________________________CITY___________STATE_________ZIP________WORK PHONE____________

DATE OF BIRTH_________________AGE_______M__F__MARITAL STATUS____________# OF CHILDREN_____________

OCCUPATION/EMPLOYER______________________________DRIVERSLICENSE#_______________SPOUSE_____________

WHO IS RESPONSIBLE FOR THIS ACCOUNT__________________________REFERRED BY___________________________

EMAIL ____

Please check the appropriate box for any of the following symptoms that you have or have had previously. I want all the facts about your health before I accept your case.

O-OCCASIONAL
F-FREQUENT
C-CONSTANT

O F C

GENERAL
- ☐☐☐ Allergy
- ☐☐☐ Chills
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Fever
- ☐☐☐ Headache
- ☐☐☐ Loss of sleep
- ☐☐☐ Weight loss
- ☐☐☐ Nervousness/depression
- ☐☐☐ Nerve pain
- ☐☐☐ Numbness
- ☐☐☐ Sweats
- ☐☐☐ Tremors

MUSCLE AND JOINT
- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Foot trouble
- ☐☐☐ Hernia
- ☐☐☐ Low back pain
- ☐☐☐ Neck pain or stiffness
- ☐☐☐ Osteoporosis
- ☐☐☐ Pain between shoulders

Pain or Numbness in:
- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hands
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet
- ☐☐☐ Painful tailbone
- ☐☐☐ Poor posture
- ☐☐☐ Sciatica
- ☐☐☐ Spinal curvature

PLEASE TURN OVER

O F C

GASTRO-INTESTINAL
- ☐☐☐ Belching or gas
- ☐☐☐ Colitis
- ☐☐☐ Colon trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult digestion
- ☐☐☐ Distention of abdomen
- ☐☐☐ Excessive hunger
- ☐☐☐ Gall bladder trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Intestinal worms
- ☐☐☐ Jaundice
- ☐☐☐ Liver trouble
- ☐☐☐ Nausea
- ☐☐☐ Pain over stomach
- ☐☐☐ Poor appetite
- ☐☐☐ Vomiting
- ☐☐☐ Vomiting of blood

EARS, EYES, NOSE, & THROAT
- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Crossed eyes
- ☐☐☐ Deafness
- ☐☐☐ Tooth ache
- ☐☐☐ Earache
- ☐☐☐ Ear discharge
- ☐☐☐ Ear noises
- ☐☐☐ Enlarged glands
- ☐☐☐ Enlarged thyroid
- ☐☐☐ Eye pain
- ☐☐☐ Failing vision
- ☐☐☐ Far sightedness
- ☐☐☐ Gum trouble
- ☐☐☐ Hay fever
- ☐☐☐ Hoarseness
- ☐☐☐ Nasal obstruction
- ☐☐☐ Near sightedness
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus infection
- ☐☐☐ Sore throat
- ☐☐☐ Tonsillitis

O F C

CARDIO-VASCULAR
- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood pressure
- ☐☐☐ Pain over heart
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid heart beat
- ☐☐☐ Slow heart beat
- ☐☐☐ Swelling of ankles
- ☐☐☐ RESPIRATORY
- ☐☐☐ Chest pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficult breathing
- ☐☐☐ Spitting up blood
- ☐☐☐ Spitting up phlegm
- ☐☐☐ Wheezing

SKIN
- ☐☐☐ Boils
- ☐☐☐ Bruise easily
- ☐☐☐ Dryness
- ☐☐☐ Hives or allergy
- ☐☐☐ Itching
- ☐☐☐ Skin eruptions
- ☐☐☐ Varicose veins

GENITO-URINARY
- ☐☐☐ Bed-wetting
- ☐☐☐ Blood in urine
- ☐☐☐ Frequent urination
- ☐☐☐ Inability to control urination
- ☐☐☐ Kidney infection or stones
- ☐☐☐ Painful urination
- ☐☐☐ Prostate trouble
- ☐☐☐ Pus in urine

FOR WOMEN ONLY
- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Excessive menstrual flow
- ☐☐☐ Hot flashes
- ☐☐☐ Irregular cycle
- ☐☐☐ Menopausal symptoms
- ☐☐☐ Painful menstruation
- ☐☐☐ Vaginal discharge

Are you pregnant? Yes ☐ No ☐

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD OR HAVE NOW:

☐ AIDS	☐ Chorea	☐ Fever blisters	☐ Miscarriage	☐ Scarlet fever
☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Multiple sclerosis	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Gout	☐ Mumps	☐ Tuberculosis
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Pleurisy	☐ Typhoid fever
☐ Arteriosclerosis	☐ Eczema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Arthritis	☐ Emphysema	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Have you ever had previous chiropractic care?_______If yes, date of last care_________Place care was given____________________
What is your current health complaint?____

____

How long have you had this condition? _________________________Have you had this in the past?___________________________
What activities aggravate your condition?____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine Other____
How long has it been since you really felt good?____
What do you believe is wrong with you?____
List previous diagnoses and treatments you have received for present condition_______________________________________
List surgical operations and years____
List the drugs you now take and how often____
Are you wearing: ☐ heel lifts ☐ sole lifts ☐ inner soles ☐ arch supports
Have you been in an auto accident: ☐ past year ☐ past five years ☐ over five years ☐ never
Describe____

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

List below all conditions for which you have been treated in the past ten years.

________________ ________________
________________ ________________
________________ ________________
________________ ________________
________________ ________________
________________ ________________
________________ ________________

Name of relative or close friend not living in your home who can be contact in case of emergency.
NAME____PHONE____
ADDRESS____

PAYMENT IS EXPECTED AT THE TIME OF VISIT:
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections for the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to me on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby give my consent to be examined at this office. I consent to allow the doctor to seek inter-and intra-professional advice relating to my particular case in order to obtain additional or collateral information that may be required to reach a complete and accurate diagnosis. Notwithstanding the foregoing, complete confidentiality of my records is assured.

I understand that my acceptance as a patient at this office is contingent upon the opinion of the examining doctor that I have a condition that is amenable to chiropractic care. If chiropractic cannot help me, I will not be accepted as a patient, but will be referred to an appropriate health care faculty.

24 hours notice is required for cancellation of an appointment. Without advance notice, full price will be charged.
A $25.00 service charge will apply to all N.S.F. checks.

SIGNATURE OF PATIENT OR GUARDIAN____DATE____________