PATIENT CONFIDENTIAL HISTORY FORM

(Please Print) Date: ________________

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________________ State: ____________ Zip: ____________

Phone: H____________ W____________ C____________ E-Mail:______________

Social Security No.: _______-______-__________ Birth Date: ____/____/____ Age: __________

Gender: ☐ Male ☐ Female Height: __________ Weight:__________

Name of Emergency Contact: ______________ Phone Number: ______________

Employer: ______________________ Insurance Company: ______________

Name of Insured: ______________________ Date of Birth of Insured: _____/_____/_______

Employer of Insured: ____

Name of Spouse or Guardian: ______________ Referred By: ______________

Marital Status:

☐ Married ☐ Domestic Partner ☐ Widowed ☐ Separated ☐ Divorced ☐ Single

Pregnant? (Female):

☐ Yes ☐ No ☐ Unsure No. Of Children: ______________

If you smoke cigarettes, how many do you smoke in an average day?

☐ Do Not Smoke ☐ Less than ½ Pack ☐ ½ to 1 Pack ☐ 1 to 2 Packs ☐ More than 2 packs

If you drink alcohol, about how many drinks in an average day? (one drink is a bottle of beer, glass of wine, one cocktail, etc.)

☐ Do not drink ☐ No more than 1 ☐ 1 or 2 drinks ☐ 3-5 drinks ☐ 6-8 drinks ☐ More than 8 drinks

Recreational/Exercise:

Type: ______________________ Frequency: ________/week Duration: _______ Min/Hrs
Type: ______________________ Frequency: ________/week Duration: _______ Min/Hrs
Type: ______________________ Frequency: ________/week Duration: _______ Min/Hrs

Are you taking any medications? ☐ No ☐ Yes If yes, please identify: ______________

____

Have you seen a Chiropractor before?: ______________ Date of Last Visit: ____/____/______

Name of Primary Care Physician: ____

Primary Complaint/Reason for Visit: ____

Family History (1. Father, 2. Mother, 3. Sister, 4. Brother): (Please X if applicable and identify all family members that apply)

Cancer ( ) #__________ Diabetes ( ) #__________ Cardiac ( ) #__________ TB ( ) #__________
CVA ( ) #__________ BP ( ) #__________ Epilepsy ( ) #__________ Other ( ) #__________

Please Initial:

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Name: ______________________________

Mark the following conditions you have had or have now:

- ☐ Allergy
- ☐ Anemia
- ☐ Constipation
- ☐ Eczema
- ☐ Low Blood Sugar/Hypo-Glycemia
- ☐ Thyroid Problems
- ☐ Venereal Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Migraine
- ☐ Angina
- ☐ Depression
- ☐ Deafness or trouble hearing
- ☐ Chronic lung disease (including Bronchitis or Emphysema)
- ☐ Sugar Diabetes(diabetes mellitus) Type I
- ☐ Lyme Disease
- ☐ AIDS/HIV
- ☐ Convulsions
- ☐ Sinusitis
- ☐ Gall Bladder
- ☐ Menstrual Cramps
- ☐ Epilepsy
- ☐ Nervousness
- ☐ Headaches
- ☐ Pleurisy
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Sciatica or chronic back problems
- ☐ Blindness or trouble seeing, even when wearing glasses?
- ☐ Sugar Diabetes(diabetes mellitus) Type II
- ☐ OTHER ______________________
- ☐ Alcoholism
- ☐ Cold Sores
- ☐ Diarrhea
- ☐ Blood Vessel Disease
- ☐ Irregular Periods
- ☐ Multiple Sclerosis
- ☐ Tuberculosis
- ☐ Neck Pain
- ☐ Gout
- ☐ Arthritis or rheumatism
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Hypertension or high blood Pressure
- ☐ Heart Attack or myocardial infarction
- ☐ Ulcer or gastrointestinal bleeding (not counting hemorrhoids)

How Long did you have pain before you first sought treatment?

- ☐ 1 week or less
- ☐ 1 to 6 weeks
- ☐ > 6 weeks but < 3 months
- ☐ 3 months to 1 year

How many times have you had this problem in the past?

- ☐ Never
- ☐ 1 to 3 episodes
- ☐ 4 or more episodes
- ☐ 4 or more episodes

When did you first have these or similar symptoms?

- ☐ Never
- ☐ Less than 6 months
- ☐ 6 months to 1 year ago
- ☐ More than a 1 year ago

Previous Treatment History for Primary Complaint						
Date	Dr./Hospital	Treatment	Response (Better/Worse)	Treatment Duration	Test(s)	Test Result

Please List all surgeries, accidents or injuries:

____ Date: ____________
____ Date: ____________
____ Date: ____________
____ Date: ____________
____ Date: ____________
____ Date: ____________

Please sign name: ______________________________ Date: ____________
(If under 18 years of age, signature of parent or guardian)