Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT

Today's Date _____

Patient's Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

SS # _____ Driver License # _____ E-mail _____

Age _____ Birth Date _____ Marital Status: S M W D No. of Children _____

Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____ Insurance Co. _____ Plan/Group # _____

Name of Spouse or Parent _____ Birth Date _____

SS # _____ Driver's License # _____

Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work phone _____ Insurance Co. _____ Plan/Group # _____

Describe the Major Complaints that bring you to our office _____

Is your condition due to an accident? Yes ____ No ____ Date of Accident _____

Type of accident? Auto ____Work/On Job ____ At Home ____Other _____

Have you ever been in an Auto Accident? Past Year _____ Past 5 years _____ Over 5 years _____ Never _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I understand if I pay by check, I hereby authorize Straight-Up Chiropractic, if my check is dishonored or returned for any reason, to electronically debit my account for the amount of the check, plus a processing fee for the state allowed limit (plus any applicable sales tax). The use of a check for payment of any services constitutes my authorization and acknowledgement of this policy and its terms. In accordance with the rules of the National Automated Clearing House, I may call (800) 423-0554 to revoke my authorization to collect the fee electronically. This does not, however, preclude Straight-Up Chiropractic from collecting the payments due them, or from collecting a return fee via other methods.

Patient's Signature _____ date _____

Spouse or Guardian's Signature _____ date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot he met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance, the deductible must be met in the beginning unless prior arrangements are made.

HEALTH QUESTIONNAIRE

Name: _____

Date:

List all your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatment? When?

Please check the conditions you have or have had:

( ) AIDS or HIV+	( ) Epilepsy	( ) Polio
( ) Anemia	( ) Hypoglycemia	( ) Rheumatic Fever
( ) Arthritis	( ) Multiple Sclerosis	( ) Tuberculosis
( ) Cancer	( ) Parkinson's Disease	( ) Venereal Disease

FAMILY HISTORY	age	health problems or cause of death
mother:		
father:		
mother's mother:		
mother's father:		
father's mother:		
father's father:		
brothers:		
sisters:		
children:		

Please check (x) all present symptoms

Name: _____

CARDIOVASCULAR
( ) general swelling
( ) swelling in legs
( ) swelling in face
( ) swelling around eyes
( ) chest pain
( ) pounding heart beat
( ) heart "jumps"
( ) rapid heart beat
( ) blue or purple skin
( ) blue or purple nailbeds
( ) fainting
( ) hypertension

VERTEBROBASILAR
( ) double vision
( ) loss of coordinaiton
( ) irregular muscle movement
( ) ringing in ears
( ) heart attack
( ) high blood pressure
( ) irregular heart beat
( ) hardening of the arteries
( ) areas of muscle weakness
( ) dizziness with nausea
( ) dizziness without nausea
( ) blurred vision
( ) fainting spells
( ) stroke
( ) diabetes
( ) pain over the heart
( ) cold hands and /or feet
( ) areas of numbness
( ) arthritis of the neck
( ) previous neck or head injury
( ) loss of memory
( ) inability to form words (talk plainly)
( ) periods of blindness in one eye
( ) areas of abnormal sensations such as burning etc.
( ) areas of numbness
( ) blood vessel disease (phlebitis etc.)
( ) check if you smoke
( ) check if any of your family members have had a stroke.
( ) check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD
( ) unusually frequent headache
( ) unusually severe headache
( ) head feels heavy
( ) vertigo
( ) light-headedness
( ) loss of smell
( ) loss of taste
( ) loss of balance
( ) dizziness

NECK
( ) pain in neck
( ) neck pain with movement
( ) swelling in neck
( ) stiff neck
( ) pinched nerve in neck
( ) neck feels out of place
( ) muscle spasms in neck
( ) grinding sounds in neck
( ) popping sounds in neck
( ) limited neck movement

SHOULDERS
( ) pain in shoulders (R-L)
( ) pain across shoulders
( ) tension in shoulders
( ) muscle spasms in shoulders
( ) can't raise arm
  ( ) above shoulder level
  ( ) over head

ARMS & HANDS
( ) pain in upper arm
( ) pain in forearm
( ) pain in hands
( ) pain in fingers
( ) sensation of pins & needles
  ( ) in arms
  ( ) in fingers
( ) fingers go to sleep
( ) hands cold
( ) swollen joints in fingers
( ) sore joints in fingers
( ) loss of grip strength

MID BACK
( ) mid back pain
( ) pain between shoulder blades
( ) sharp stabbing pain
( ) dull ache
( ) pain from front to back
( ) pain over kidney area
( ) muscle spasms in mid back

LOW BACK
( ) low back pain
( ) low back feels out of place
( ) muscle spasms in low back

HIPS, LEGS, & FEET
( ) pain in buttocks
( ) pain down leg
( ) knee pain
( ) leg cramps
( ) pins & needles in legs
( ) numbness in leg
( ) numbness in toes
( ) cold feet
( ) swollen ankles
( ) swollen feet

HEALTH REVIEW

Name: _____

SKIN HAIR NAILS
( ) eczema
( ) itchy skin
( ) dry scalp
( ) oily scalp
( ) rough, scaly skin
( ) dry skin
( ) oily skin
( ) psoriasis
( ) yellow skin
( ) bruise easily
( ) paper thin nails
( ) pale skin
( ) nail biting
( ) baldness

EYES
( ) blurring of vision
( ) double vision
( ) eyes fatique easily
( ) excessive tearing
( ) lack of tearing
( ) light bothers eyes
( ) excessive itching
( ) pain in eyeball

EARS
( ) loss of hearing
( ) pain in ears
( ) discharge from ears
( ) vertigo
( ) ringing in ears

NOSE NASOPHARYNX SINUSES
( ) unusual nasal discharge
( ) nose bleeds
( ) pressure over eyes
( ) pressure under eyes
( ) obstruction of nose
( ) frequent colds
( ) sinusitis
( ) nasal allergies
( ) loss of sense of smell
( ) any trauma to nose

MOUTH AND THROAT
( ) pain in mouth
( ) pain in throat
( ) bleeding gums
( ) cavities
( ) abscessed teeth
( ) dentures
( ) difficulty swallowing
( ) changes in voice

RESPIRATORY
( ) shortness of breath
( ) can't breathe while lying down
( ) can't sleep while lying down
( ) dry cough
( ) productive cough
( ) coughing up blood
( ) wheezing

GASTROINTESTINAL
( ) poor appetite
( ) constant nibbling
( ) difficulty in swallowing
( ) indigestion
( ) can't eat some foods
( ) nausea & vomiting
( ) jaundice
( ) abdominal pain
( ) change in bowel habits
( ) diarrhea
( ) constipation
( ) hemorrhoids

GENITOURINARY
urination is ( ) frequent
( ) normal
( ) infrequent
the amount is ( ) high
( ) normal
( ) low

( ) need to get up at night to urinate
( ) abnormal intense desire to urinate
( ) difficulty starting urination
( ) decreased output
( ) pain on urination
( ) dribbling
( ) blood in urine
( ) cloudy urine
( ) lack of bladder control
( ) abdominal pain

VENEREAL DISEASE
( ) AIDS
( ) syphilis
( ) gonorrhea
( ) other

SOCIAL HISTORY
( ) smoking
( ) other tobacco use
( ) alcohol use
( ) drink coffee or tea

diet is ( ) balanced
( ) not balanced

rest is ( ) sufficient
( ) not sufficient

recreation is ( ) sufficient
( ) not sufficient

my familiy stress is ( ) severe
( ) moderate
( ) minimal
( ) none

how do you like your work?
( ) I like it very much
( ) It's ok
( ) I hate it

my job stress is ( ) severe
( ) moderate
( ) minimal
( ) none

( ) nervousness
( ) irritability
( ) fatigue
( ) depression
( ) generally feel run-down
( ) crave sweets
( ) crave salt

WOMEN ONLY
( ) painful period
( ) spotting
( ) vaginal discharge
( ) premenstural symptoms
( ) irregular periods
( ) lumps in breast

pregnancies _____

of deliveries _____