HEALTHQUEST CHIROPRACTIC

WELCOME

Today's Date: ____/____/____ File_____

Name: _____ Birthday: ____/____/____

Age: _____ What you prefer to be called: _____ [ ] Male [ ] Female

SSN#_____ Height: _____ Weight: _____

[ ] Single [ ] Married [ ] Widow [ ] Divorced [ ] Separated Children#:____

Home Address: _____ Home Phone: _____

City/ State/ Zip: _____ Work Phone: _____

Spouse's Name: _____

Employer: _____ Occupation: _____

Work Address: _____

City/ State/ Zip: _____

Referred by: _____

Have you ever been treated by a Chiropractic physician? [ ] Yes [ ] No

If so please explain: _____

Date of last treatment: ____/____/____

Medical doctor's name: _____ Phone: _____

Reason for visit: _____

Explain what happened: _____

_____

Date condition began: ____/____/____

Describe location of condition or pain: _____

Is pain: [ ] dull [ ] sharp [ ] achy [ ] burning [ ] shooting [ ] deep [ ] superficial
[ ] mild [ ] moderate [ ] severe [ ] constant [ ] frequent [ ] occasional

What makes it better? _____

What makes it worse? _____

Does this affect how you work, sleep, etc.? [ ] Yes [ ] No

If so, explain: _____

Have you had this or similar conditions in the past? [ ] Yes [ ] No How long ago? _____

Have you tried any home remedies? _____

Have you seen any other physician for this condition? _____

Date of last treatment: ____/____/____

Taking any medication for condition (list)? _____

Have you had any x-rays taken? [ ] Yes [ ] No

If so, when and where? _____

Health History: Have you ever had any of the following?

[ ] Heart Attack/ Stroke
[ ] Heart Surgery
[ ] Pacemaker
[ ] Heart Murmur
[ ] Artificial Valves
[ ] Congenital Heart Defect
[ ] Mitral Valve Prolaps
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Artificial Joints
[ ] Psychiatric Problems

[ ] Fainting/ Seizures/ Epilepsy
[ ] Severe Headaches
[ ] Diabetes
[ ] Alcohol/ Drug Abuse
[ ] HIV+/ AIDS
[ ] Urinary Tract Infection
[ ] Shingles
[ ] Emphysema
[ ] Pleurisy
[ ] Thyroid Conditions
[ ] Eczema/ Psoriasis

[ ] Hepatitis
[ ] Cirrhosis of liver
[ ] Anemia
[ ] Cancer
[ ] Kidney Problems
[ ] Venereal Disease
[ ] Kidney Stones
[ ] Prostate
[ ] Ulcers/ Colitis
[ ] Asthma
[ ] Arthritis

Please list any other serious medical conditions you have or ever had: _____

_____

Dr.Notes: _____

_____

Musculo-Skeletal:

[ ] Neck Pain
[ ] Pain between shoulders
[ ] Arm Pain
(shoulder, wrist, elbow, hand)
[ ] Low Back Pain
[ ] Leg Pain
(hip, knee, ankle, foot)
[ ] Joint Pain/ Stiffness
[ ] Walking Problems
[ ] Clicking/ Painful Jaw

Respiratory:

[ ] Chronic Cough
[ ] Cough w/ phlegm
[ ] Cough w/ blood
[ ] Difficult breathing
[ ] Pain when breathing

Cardio-Vascular:

[ ] Ankle Swelling
[ ] Chest Pain
[ ] Irregular Heart Beat

Nervous System:

[ ] Numbness
[ ] Paralysis
[ ] Dizziness/ Equilibrium
[ ] Confusion
[ ] Depression
[ ] Stress
[ ] Tremors
[ ] Incoordination
[ ] Tastes/ Smell

EENT:

[ ] Vision Problems
[ ] Hearing Difficulty
[ ] Earaches
[ ] Dental Problems
[ ] Sore Throat
[ ] Stuffy Nose/ Sinus

Genito/ Urinary:

[ ] Frequent Urination
[ ] Painful Urination
[ ] Blood in Urine
[ ] Bed Wetting
[ ] Discolored Urine

Gastro-intestinal:

[ ] Gas/ Burning
[ ] Nausea/ Vomiting
[ ] Heartburn
[ ] Diarrhea
[ ] Constipation
[ ] Hemorrhoids
[ ] Black/ Bloody Stools

Skin:

[ ] Boils
[ ] Hives
[ ] Pimples
[ ] Rashes
[ ] Excessive Sweating
[ ] Dryness

General Symptoms:

[ ] Headaches
[ ] Fatigue
[ ] Fever/ Chills
[ ] Weight Loss/ Gain
[ ] Loss of Sleep

Family History:

[ ] Cancer
[ ] Diabetes
[ ] Rheumatoid Arthritis
[ ] Lung
[ ] Heart
Other: _____

Female:

[ ] Painful Menstruation
[ ] Vaginal Discharge
[ ] Irregular Cycle
[ ] Excessive Flow
[ ] Breast Tenderness
[ ] Breast Nodules
[ ] Menopause
[ ] Estrogen/ Progesterone Repl.
[ ] Birth Control
[ ] Currently Pregnant
[ ] Nursing

Past Illness:

[ ] Measles
[ ] Mumps
[ ] Small Pox
[ ] Whooping Cough
[ ] Chickenpox
[ ] Diptheria
[ ] Appendicitis
[ ] Rheumatic Fever
[ ] Pneumonia

Past Surgeries & Dates: _____

Past Injuries/ Fractures: _____

Auto Accidents & Dates: _____

Known Allergies: _____

All Medications: _____

Do You: Smoke [ ] No [ ] Yes How Long? _____

Alcohol [ ] No [ ] Yes How Often? _____

Exercise [ ] Never [ ] Occasional [ ] Regular [ ] Excessive

Are you wearing lifts or supports in your shoes? [ ] Yes [ ] No Type: _____

Mattress: [ ] Firm [ ] Medium [ ] Soft

How do you sleep? [ ] Back [ ] Side [ ] Stomach

Pillows? _____

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*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

*Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with us. I understand that I am financially responsible for all charges.

* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process claims.

*I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** ____/____/____

Guardian Signature: _____