PATIENT HEALTH HISTORY

Name: ______________________________ Age: ________ **Birth Date:** ______________________

Address: ____

City: ______________________________ **State:** _________ **Zip Code:** ______________________

Email Address: ______________________________ **How did you hear about our office?** ____________

Cell Phone #: ____________________________ **Home Phone #:** ______________________________

Gender: ____________________ **Height:** _______**ft** ________**inches** **Weight:** ___________

Marital Status: _______________________ **Spouse's Name**: ______________________________

Names of Children & Ages: _______________________, _______________________, ____________________

Occupation: ____________________________________ **Employer:** ______________________________

Social History

Habits:

Smoking: ☐No ☐Yes Packs per Day: ____________ # of Years: ________________

Alcohol: ☐No ☐Yes Frequency: ____

Caffeine: ☐No ☐Yes Type: _______________________ Frequency: _______________

Exercise: ☐ None ☐ 1-2 days ☐ 3-4 days ☐5-6 days ☐Everyday

Preferred form(s) of exercise: ____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

☐ Appendicitis ☐ Anemia ☐ Heart Attack ☐ Arthritis

☐ Pneumonia ☐ Measles ☐ Cancer ☐ Epilepsy

☐ Rheumatic Fever ☐Mumps ☐ Scoliosis ☐ Mental Disorder

☐ Polio ☐ Chicken Pox ☐ Pleurisy ☐ Addiction

☐ Tuberculosis ☐ Shingles ☐ Gout ☐ Eating Disorder

☐ Whooping Cough ☐ Diabetes ☐ Stroke ☐ HIV

OPERATION & PROCEDURES

** **Please include date of operation/procedure**

☐ Stomach ____________ ☐ Tonsillectomy _________ ☐ Gall Bladder_____________ ☐ Back Surgery____

☐ Tubes in Ears _________ ☐ Appendectomy ________ ☐ Female Organs _________ ☐ Neck Surgery____

☐ Sinus _________________ ☐ Hernia _________________ ☐ Thyroid________________ ☐ Other: __________

GENERAL SYMPTOMS

☐ Allergy (What?) _______________
☐ Dizziness
☐ Fatigue
☐ Headaches
☐ Loss of Sleep
☐ Night Sweats
☐ Weight Loss

CARDIOVASCULAR

☐ Poor Circulation
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pain over Heart

Digestion

☐ Celiac Disease
☐ Crohn's Disease
☐ Irritable Bowel Syndrome
☐ Constipation
☐ Diarrhea
☐ Frequent Urination
☐ Inability to Control Urine
☐ Painful Urination
☐ Excessive Thirst
☐ Bed Wetting
☐ Acid Reflex
☐ Heartburn

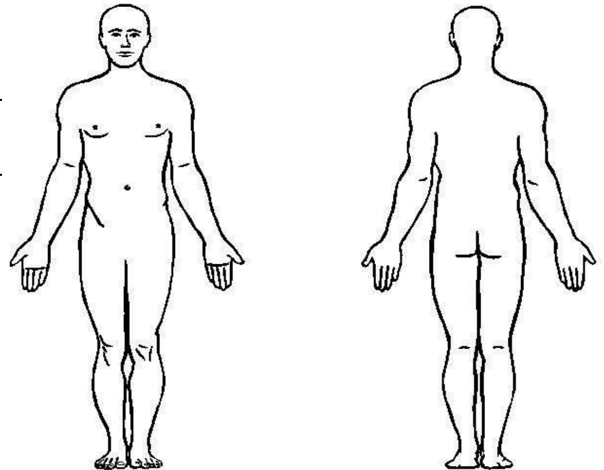
RESPIRATORY

☐ Chest Pain
☐ Chronic Cough/Mucous
☐ Difficulty Breathing
☐ Coughing Up Blood
☐ Asthma

FOR WOMEN ONLY

☐ Menstrual Cramps
☐ Hot Flashes
☐ Irregular Cycle
☐ Pregnancy (now)
☐ Miscarriage
☐ In Vitro Fertilization

Primary Complaint:



Location of Pain: __________________ Duration**: (how long?)** _______

What brought on the Pain? ____

Circle how you would describe the Pain:
Radiating Burning Dull Aching Numbness

Sharp/Stabbing Tingling Other: ______________________

Rate the Pain: 1-10 (10=worst pain ever) ________________________

What makes it Better? ____

What makes it Worse? ____

Does the Pain travel to another area of the body? ☐ No ☐ Yes - Where? ___________________________________

Is there a time of day where the pain is more noticeable? ____

Secondary Complaint

Location of Pain: ________________________ Duration**: (how long?)** ___________ Rate the Pain: 1-10 ___________

What brought on the Pain? ____

Circle how you would describe the Pain:
Radiating Burning Dull Aching Numbness Sharp/Stabbing Tingling
Other: _______________________

Activities of Life

Please select any that are impacted by your present condition

Activity				
Carry Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lift Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: ___________________	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

Medications: (prescriptions/over the counter)

Medications	Reason for Taking

Accidents/Falls/Past Injuries

List any incidents; please include the dates.

☐ Car Accidents ____

☐ Work Injuries/Falls ____

Ever on **Crutches**? ☐ No ☐ Yes Why? ________________

Ever Had a **Concussion**: ☐ No ☐ Yes

Broken Bones/Fractures:

Areas of the Body:	Date

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at E320 Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I understand and agree that the accident and health insurance policies are an arrangement between an insurance carrier and myself. I understand that E320 Chiropractic LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered are charged to me directly and that I am personally responsible for all charges at the time of service.

Patient Signature: ____ Date: ______________________

MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Name: ____

Release of Information: I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse: ____ ☐ Information is not to be released to anyone.

☐ Other: ____

This Release of Information will remain in effect until terminated by me in writing.

Messages: (If we are unable to reach you)

☐ You may leave a detailed message ☐ Please leave a message asking me to return your call

☐ Send a text Message ☐ Send an email

Signed: ____ **Date:** _______________________

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files.

At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is $15.00.** This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day. Please Note: x-rays are utilized in this office to help locate and analyze vertebral subluxations.

These x-rays are not used to investigate medical pathology. The doctor of E320 Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By Signing Below, you are agreeing to the above terms and conditions.

Signed: ____ **Date:** _______________________

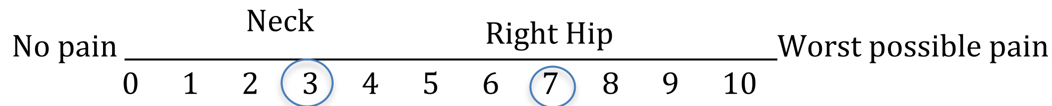
Female Patients: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken at E320 Chiropractic.

Signed: ____ **Date:** _______________________

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:



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1. **How would you rate your pain RIGHT NOW?**

   ____
   0 1 2 3 4 5 6 7 8 9 10

2. **What is your typical or AVERAGE pain?**

   ____
   0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level at its BEST? (How close to 0 does your pain get at its best?)**

   ____
   0 1 2 3 4 5 6 7 8 9 10

   What percentage of your awake hours is your pain at its best? _____%

4. **What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)**

   ____
   0 1 2 3 4 5 6 7 8 9 10

   What percentage of your awake hours is your pain at its worst? _____%