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

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

Accidents/Falls/Past Injuries

1. Have you been involved in a **car accident**? ☐ No ☐Yes → List Year(s): _____
2. Have you been involved in any **work injuries/falls**? ☐ No ☐Yes → Explain: _____
3. Have you ever been in **crutches**? ☐ No ☐Yes → Explain: _____
4. Have you ever had a **concussion**? ☐ No ☐Yes → Explain: _____
5. Have you had any **broken bones/fractures**? ☐ No ☐Yes → **Please List Below**

   1._____ Date: _____

   2._____ Date: _____

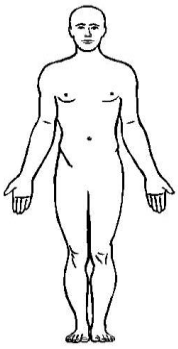
   3._____ Date: _____

Medications: (prescriptions/over the counter)

Are you taking any **prescription** or **over the counter** medication? ☐ No ☐Yes → **Please List Below**

Medications	Reason for Taking

Primary Complaint:

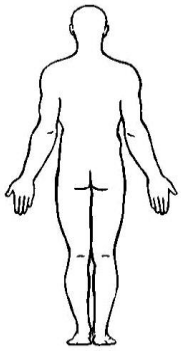


Location of Pain: _____ Duration: (**how long?**) _____

What brought on the Pain? _____ Rate the Pain: 1-10 (10=worst pain ever) _____

Describe the Pain/Discomfort:

Dull	Deep Bruising	Tingling	Sharp	Radiating	Aching
Stabbing	Stiffness	Cramping	Tightness	Throbbing	Soreness
Burning	Needs Stretching	Numbness	Other: _____		



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? _____

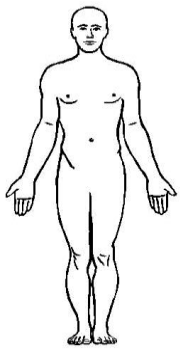
Aggravates:

Sitting	Straining	Stooping
Sleeping	Rest	Reaching
Looking Up	Exercise	Lying on Back
Typing	Standing	Lying on Stomach
Sneezing	Looking Down	Lifting
Picking Up	Walking	Twisting
Coughing	Movement	Driving
House Chores	Bending	Climbing Stairs

Relieves:

Sitting	Movement	No Movement
Medication	Ibuprofen	Support/Brace
Knees Bent Up	Ice	Analgesic Topical
Rest	Stretching	Lying Flat
Exercise	Heat	Standing

Secondary Complaint



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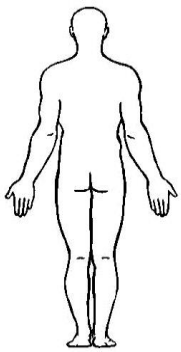

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Exercise	Heat	Standing

Activities of Life

Please select any that are impacted by your present condition

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/Grooming	○ 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

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:** _____

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:** _____

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.

QVAS Score

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 **BES**T?

   0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its **WORST**?

   0 1 2 3 4 5 6 7 8 9 10