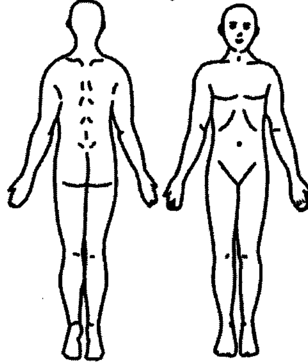
Patient Condition

Reason for today's visit: ______________________________
When did your symptoms first appear?: ______________________________
What occurred to contribute to the onset of your symptoms? ______________________________
____
Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? (Circle correct answer)
Has the intensity of your pain been getting better, worse or staying the same? (Circle the correct answer)
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
Other treatments for this condition: ☐ Medication ☐ Physical Therapy ☐ Massage ☐ Surgery
Are there any existing diagnostic studies related to your condition or area of complaint? Yes/No

Please indicate the location of your **pain** by placing an "X" over the involved area(s).

Please indicate any areas of **numbness or tingling** by placing a "✓" over the involved area(s).



Any additional information on your condition you would like to add: ______________________________
____
____
____
____

Please list all medications currently used (Prescription or Over the Counter): ______________________________
____
____

Please list all nutritional supplements currently used: ______________________________
____

Do you exercise? ________ If so, what type? ______________ How often? ______________

Health History

☐ AIDS/HIV	☐ Diabetes	☐ High Blood Pressure	☐ Osteopenia	☐ Spinal Surgery
☐ Allergy Shots	☐ Emphysema	☐ High Cholesterol	☐ Osteoporosis	☐ Stroke
☐ Anemia	☐ Epilepsy	☐ Irritable Bowel Synd.	☐ Pacemaker	☐ Thyroid Problems
☐ Arthritis	☐ Fibromyalgia	☐ Joint Replacement	☐ Parkinson's Disease	☐ Tuberculosis
☐ Asthma	☐ Glaucoma	☐ Kidney Disease	☐ Polio	☐ Tumors
☐ Breast Cancer	☐ Gout	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Cancer	☐ Heart Disease	☐ Meniere's Disease	☐ Psoriasis	☐ Vertigo
☐ Carotid Artery Surgery	☐ Hepatitis	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Other __________
☐ Chronic Fatigue Synd.	☐ Hernia	☐ Mononucleosis	☐ Shoulder Surgery	__________
☐ Colitis	☐ Herniated Disc	☐ Multiple Sclerosis	☐ Spinal Fractures	__________

Female Specific

Are you currently pregnant? Yes/No Date of last menstrual flow: ______________________________
Are you currently experiencing symptoms associated with menopause? Yes/No
Are you post-menopausal? Yes/No If so, for how long? ______________________________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________
Name of Insurance Company(ies)
and assign directly to Phillips Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Please print name of Patient, Parent, Guardian or Personal Representative

____
Relationship to Patient