PAPE CHIROPRACTIC & WELLNESS CENTER

CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____Today's Date:_____Gender: **M F**

Address:_____City_____State____Zip_____

Social Security #:_____ Birthdate:_____ Age:_____

Occupation:_____ Marital Status: M S W D No. of Children:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact Name:_____Emergency Contact Phone:_____

Spouse's Name:_____ Spouse's Phone:_____

How did you hear about us?_____

E-mail Address:_____

By providing an email address, I authorize my doctor to contact me.* *Federal guidelines now require an electronic way to send your record directly.

Purpose of this appointment?_____

List surgeries and dates:_____

List current Medications/Frequency and doses:_____

_____Phamacy:_____

List current Vitamin Supplements:_____

Allergies, Food and Medicines:_____Date of last physical exam:_____

What tests have you previously had related to the purpose of today's appointment? (please check all that apply)

_____XRAY _____MRI _____CTScan _____Lab Tests/ Blood work _____Other

Who is your primary care physician and phone number?_____

Have you been diagnosed with Hypertension or Diabetes? When? _____

Have you been diagnosed with HIV/AIDS?_____ Have you been diagnosed with HEP C? _____

Have you had previous chiropractic care? **Y N** When was your last chiropractic visit?_____

Do you exercise? ____Yes ____No If yes, how often do you exercise?_____

Do you have regular bowel movements?___Yes___No How much water do you drink daily?_____

How is your overall diet?_____What hobbies do you enjoy?_____

*What city were you born in? _____

*Verification question to access you medical records online.

PLEASE CHECK ANY SYMPTOMS THAT YOU HAVE HAD IN THE RECENT PAST OR ARE CURRENTLY EXPERIENCING

GENERAL

____ Weight Change
____ Fever/Chills
____ Loss of Energy
____ Change in Appetite
____ Anxiety
____ Depression
____ Diabetes
____ Difficulty Sleeping
____ Heat/Cold Intolerance
____ Nausea/Vomiting

FAMILY HISTORY

____ Diabetes
____ Thyroid Disease
____ Kidney/Bladder
____ High Blood Pressure
____ Musculoskeletal
____ Cancer
____ Heart Disease
____ Neurological

EYES

____Pain/Burning
____Double Vision

NOSE/THROAT

____Chronic Discharge
____Nosebleeds
____Hoarseness
____Trouble Swallowing

MUSCULOSKELETAL

____TMJ
____Neck Pain
____Shoulders
____Mid Back
____Low Back
____Elbows
____Wrists
____Hands
____Hips
____Knees
____Ankles
____Feet

HABITS

____Tobacco How Much?
____Coffee/Tea
____Occupational Exposure
____Alcohol

EARS

____Loss of Hearing
____Ringing
____Pain

URINE

____Burning Sensation
____Change in Color
____Change in Smell
____Awaken to Urinate

ABDOMEN

____Food Allergy
____Pain
____Cramps
____Diarrhea
____Constipation
____Change in Stool

CHEST

____Pain
____Cough
____Shortness of Breath
____Heart Palpitations

NEUROLOGICAL

____Headaches
____Seizures
____Dizziness
____Weakness
____Head Trauma
____Stroke

BREASTS

____Masses
____Discharge
____Currently Nursing

FOR WOMEN

____Perimenopausal
____Hysterectomy (yr _____)
Date of last Menstruation_____

Do you have any interest in quitting smoking? _____