

CONFIDENTIAL PATIENT HISTORY

(1)

Date: _____
Full Name: _____
Name of Wife, Husband or Guardian: _____
Address: _____
City: _____ Zip _____
Phone: H() _____ W() _____ Cell() _____
Email Address: _____
Marital Status: M S W D Age: _____ Birth date: _____ # of children _____
Social Security # _____ Height: _____ Weight: _____ Could you be pregnant? _____
Occupation: _____ Employer's Name & Address _____
Spouse's Occupation /Employer: _____
Name and Address of Nearest Relative _____
(Not living with you) Phone Number: () _____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

List Chiropractors that you've seen before:

1. Name: _____ This experience was good/bad/indifferent? Circle one please
When? _____ What did they find? _____
2. Name: _____ This experience was good/bad/indifferent? Circle one please
When? _____ What did they find? _____

Present Family Doctor _____
Address: _____ Phone: _____
Date of last physical examination _____ Doctor who did exam _____

Other Medical Doctor consulted within the past year:

1. Name: _____ Address: _____
When? _____ What did they find? _____
2. Name: _____ Address: _____
When? _____ What did they find? _____

Do you brush your teeth to have healthy teeth and gums? _____ or do you brush your teeth to evade bad breath and tooth decay? _____

What do we need to do for you so that you 'd be willing to tell others about your chiropractic experience in our office? _____

List your Pains/Complaints from Most Severe (Pain #1) to Least (Pain #4)

	Location of Pain #1	Location of Pain #2	Location of Pain #3	Location of Pain #4
Today, you have the following physical complaints:	_____	_____	_____	_____
Is this Complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (explain)?	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting
How often do you feel this Complaint? <i>Ok to pick a few</i>	<input type="checkbox"/> Constant <input type="checkbox"/> Off & On <input type="checkbox"/> Daily #of times per wk _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<input type="checkbox"/> Constant <input type="checkbox"/> Off & On <input type="checkbox"/> Daily #of times per wk _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<input type="checkbox"/> Constant <input type="checkbox"/> Off & On <input type="checkbox"/> Daily # of times per week _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<input type="checkbox"/> Constant <input type="checkbox"/> Off & On <input type="checkbox"/> Daily # of times per week _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
How long have you had this?	_____	_____	_____	_____
Since it began, it is getting:	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse
What makes it better?	_____	_____	_____	_____
What makes it worse?	_____	_____	_____	_____
Is there a time of day this is better or worse?	_____	_____	_____	_____
Does the pain radiate or travel anywhere?	_____	_____	_____	_____
On a scale of 1-10 →	10 9 8 7 6 5 4 3 2 1 0	10 9 8 7 6 5 4 3 2 1 0	10 9 8 7 6 5 4 3 2 1 0	10 9 8 7 6 5 4 3 2 1 0
Rate discomfort: (Circle 2#'s for hi and lo)	10 = Excruciating 0 = No Discomfort	10 = Excruciating 0 = No Discomfort	10 = Excruciating 0 = No Discomfort	10 = Excruciating 0 = No Discomfort
How have you taken care of this, & how has it worked?	_____	_____	_____	_____
This issue is affecting my:	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine <input type="checkbox"/> Ability to Exercise	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine <input type="checkbox"/> Ability to Exercise	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finance <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine <input type="checkbox"/> Ability to Exercise	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine <input type="checkbox"/> Ability to Exercise
Helping this issue would increase my quality of Life by:	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75 <input type="checkbox"/> 80-100%	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs & desires when recommending your health program.

~Please check the type of care desired so that we may be guided by your wishes. You can check more than one
 Relief Correction of the cause Prevention Let the Doctor choose for me

Surgery: (Please include all surgeries)

- 1. Type: _____ When: _____ Doctor: _____
- 2. Type: _____ When: _____ Doctor: _____
- 3. Type: _____ When: _____ Doctor: _____
- 4. Type: _____ When: _____ Doctor: _____

(If additional space is needed please continue on another sheet)

Accidents and/or injuries: (Especially those related to your present problems).

- 1. Type: _____ When: _____ Hospitalized: y _____ n _____
- 2. Type: _____ When: _____ Hospitalized: y _____ n _____
- 3. Type: _____ When: _____ Hospitalized: y _____ n _____

NOTE: If you have RECENTLY been involved in an accident or injury, please request and fill out our accident report form, which may be obtained from the front desk staff.

Check the following conditions you may have had or do have now:

- | | | | |
|------------------------|-------------------------|--------------------------|------------------------|
| _____ Allergy | _____ Diarrhea | _____ Measles | _____ Rheumatic Fever |
| _____ Alcoholism | _____ Eczema | _____ Miscarriage | _____ Stroke |
| _____ Anemia | _____ Emphysema | _____ Multiple Sclerosis | _____ Heart Attack |
| _____ Arteriosclerosis | _____ Gall Bladder | _____ Mumps | _____ Tuberculosis |
| _____ Arthritis | _____ Gout | _____ Neuritis | _____ Thyroid Problems |
| _____ Backaches | _____ High BP | _____ Nervousness | _____ Ulcers |
| _____ Cancer | _____ Heart Disease | _____ Depression | _____ Venereal Disease |
| _____ Convulsions | _____ Malaria | _____ Pleurisy | _____ Whooping Cough |
| _____ Constipation | _____ Menstrual Cramps | _____ Pneumonia | _____ Low Blood Sugar |
| _____ Cold Sores | _____ Irregular Periods | _____ Polio | _____ Neck Pain |
| _____ Diabetes | _____ Migraine | _____ Headaches | _____ Back Pain |
| _____ Sinus | _____ Epilepsy | _____ Ringing in Ears | _____ Shoulder Pain |

Are you interested in improving your posture? Yes _____ No _____

Are you interested in finding out ways to prevent cancer heart disease, and how to get all the nutrients you need? Yes _____ No _____

Are you interested in finding out how we can help you lose weight? Yes _____ No _____

How important is a drug-free anti-aging program to you? Mild Important/Neutrally/Very Important Circle one please

Please list all current medications you are taking? _____

Please list all vitamin supplements you are currently taking? _____

Please list all current forms of regular exercise and # of times per week you perform them _____

Name of person responsible for payment: _____

Do you have insurance that covers chiropractic care? _____

Name of insurance company: _____ policy # _____

Insured's Social Security # _____ Insured's Date of Birth: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Ginsberg Chiropractic PC may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to Ginsberg Chiropractic PC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and treatment, and any fees for professional services rendered me will be immediately due and payable. Unpaid balances after 30 days may accrue interest at 1.5% per month.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____