

Doholis Chiropractic Confidential Patient Information

Date _____ SS# _____

Name _____ Phone # _____

Local Address _____ City/State/Zip _____

Other Address _____ City/State/Zip _____

Age _____ Birth Date ____ / ____ / ____ Marital Status: S M W D How Many Children _____

Occupation _____ Employer _____ Work Phone# _____

Work Address _____ City/State/Zip _____

Name of Spouse _____ Occupation _____ Employer _____

Work Address _____ City/State/Zip _____ Phone# _____

Who referred you to our office? _____

List present complaints, injuries and duration and when specifically the symptoms or pain began:

1. _____

2. _____

Brief remarks and details of any recent related accident:

Are your symptoms:

getting worse, getting better, or staying the same?

List any doctors consulted for present complaints and injuries:

Name _____ Specialty _____

Address _____

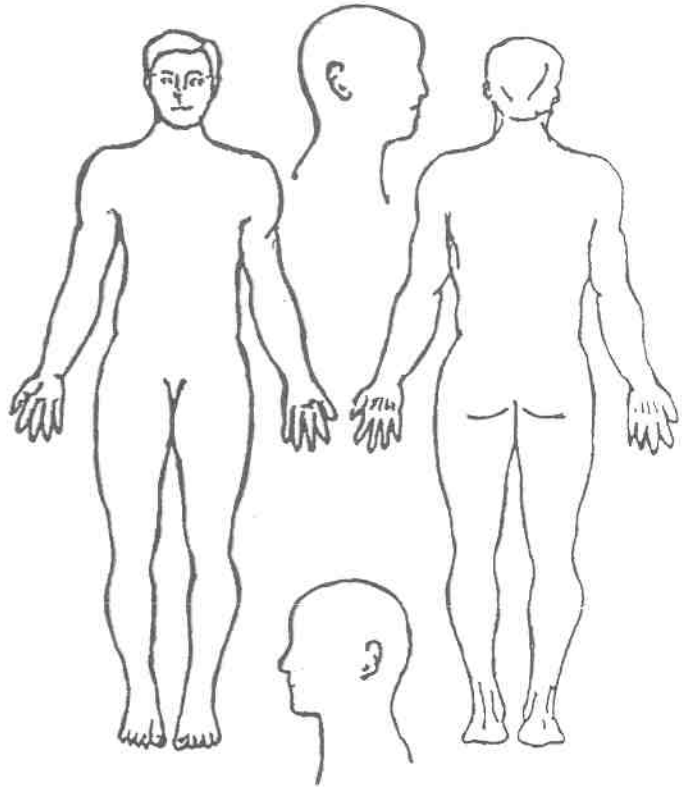
Consulted from _____ to _____

Name _____ Specialty _____

Address _____

Consulted from _____ to _____

Please mark your areas of pain on the figures below:



0-----5-----10
How bad is your pain (0 being tolerable to 10 intolerable)

Doholis Chiropractic Patient Information

Name: _____ Date: _____

Please check off any of the following symptoms you have experienced:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Constipation | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> _____ |

1. Does this cause you to be:

- Moody
- Irritable
- Interrupt Sleep
- Restricted on Daily Activities

2. Does this affect your work:

- Decision Making
- Poor Attitude
- Decreased Productivity
- Exhausted at End of Day
- Unable to Work Long Hours

3. Does this affect your life:

- Lose Patience with Spouse or Children
- Restricted Household Duties
- Hinders Ability to Exercise or Participate in Sports

A. How long have you noticed this? Weeks _____ Months _____ Years _____

B. Would you like to find out what could be causing your problem? Yes No

Doholis Chiropractic Patient Past Health History

What surgeries have you had and/or fractures or broken bones, etc.? (Type, When, Doctor, Remarks)

List former serious accidents, injuries and/or falls: (Auto, Work, Home, Leisure, Other) (What, When, Symptoms, Treatment, Results)

List medications and/or diet supplements you take: (What, Frequency, Doctor(s), Side Effects, How Long Taken, Remarks)

Do you wear orthotics, heel or sole lifts, in your shoes? _____

Occupational (Please circle appropriate answer and give details below)

I Spend the Day — Seated / Standing Work Bench / Desk Counter / Other

Job Involves — Lifting (how much) _____ / Bending / Stooping / Twisting / Turning / Carrying / Walking / Standing / Other

Chair — Executive / Steno / Bench / Stool / Folding / Other _____

Shoes — High Heels / Boots / Other _____

Do any work activities aggravate your present main complaints? Describe: _____

Comments: _____

Leisure

Sedentary Activities — TV / Reading / Card Games / Sewing / Other (circle all applicable and describe how long) _____

Strenuous Activities — Sports / Exercise (type, frequency, length of time) Have you had to discontinue any activities? _____

Describe: _____

How would you grade your general stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed

Physical activity at work: Sedentary more than 50% of workday Light manual labor Manual labor Heavy manual labor

General physical activity: No regular program Light exercise program Strenuous exercise program

X-Ray Confirmation: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signed: _____

Consent to Treat a Minor Child: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

Signed: _____ (Parent / Legal Guardian)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

Furthermore, I understand that this chiropractic office 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 directly to this chiropractic office 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 that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Information Taken By: _____ Date: _____