

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

☐ No ☐ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

☐ Male ☐ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

☐ Yes ☐ No

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

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1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle): ☐ An accident or injury

☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

3. Onset (When did you first notice your current symptoms?) _____

4. Intensity (How extreme are your current symptoms?) _____

5. Duration and Timing (When did it start and how often do you feel it?)

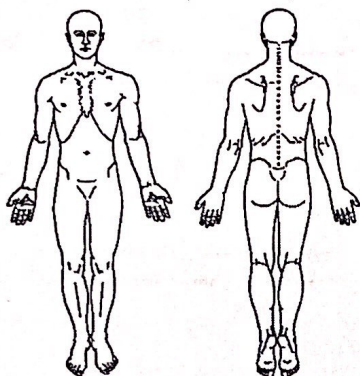
☐ Constant ☐ Comes and goes. How Often? _____

0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10
Absent Uncomfortable Agonizing

6. Quality of symptoms (What does it feel like?)

- ☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramps
☐ Nagging
☐ Sharp
☐ Burning
☐ Shooting
☐ Throbbing
☐ Stabbing
☐ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- ☐ Prescription medication ☐ Surgery ☐ Ice
☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat
☐ Homeopathic remedies ☐ Chiropractic ☐ Other _____
☐ Physical therapy ☐ Massage _____

11. What else should Dr. Gomez know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have <input type="radio"/> Osteoporosis	Had Have <input type="radio"/> Arthritis	Had Have <input type="radio"/> Scoliosis	Had Have <input type="radio"/> Neck pain	Had Have <input type="radio"/> Back problems	Had Have <input type="radio"/> Hip disorders	NONE <input type="radio"/>
<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	Initials _____

b. Neurological

Had Have <input type="radio"/> Anxiety	Had Have <input type="radio"/> Depression	Had Have <input type="radio"/> Headache	Had Have <input type="radio"/> Dizziness	Had Have <input type="radio"/> Pins and needles	Had Have <input type="radio"/> Numbness	NONE <input type="radio"/>
						Initials _____

c. Cardiovascular

Had Have <input type="radio"/> High blood pressure	Had Have <input type="radio"/> Low blood pressure	Had Have <input type="radio"/> High cholesterol	Had Have <input type="radio"/> Poor circulation	Had Have <input type="radio"/> Angina	Had Have <input type="radio"/> Excessive bruising	NONE <input type="radio"/>
						Initials _____

d. Respiratory

Had Have <input type="radio"/> Asthma	Had Have <input type="radio"/> Apnea	Had Have <input type="radio"/> Emphysema	Had Have <input type="radio"/> Hay fever	Had Have <input type="radio"/> Shortness of breath	Had Have <input type="radio"/> Pneumonia	NONE <input type="radio"/>
						Initials _____

e. Digestive

Had Have <input type="radio"/> Anorexia/bulimia	Had Have <input type="radio"/> Ulcer	Had Have <input type="radio"/> Food sensitivities	Had Have <input type="radio"/> Heartburn	Had Have <input type="radio"/> Constipation	Had Have <input type="radio"/> Diarrhea	NONE <input type="radio"/>
						Initials _____

f. Sensory

Had Have <input type="radio"/> Blurred vision	Had Have <input type="radio"/> Ringing in ears	Had Have <input type="radio"/> Hearing loss	Had Have <input type="radio"/> Chronic ear infection	Had Have <input type="radio"/> Loss of smell	Had Have <input type="radio"/> Loss of taste	NONE <input type="radio"/>
						Initials _____

g. Integumentary

Had Have <input type="radio"/> Skin cancer	Had Have <input type="radio"/> Psoriasis	Had Have <input type="radio"/> Eczema	Had Have <input type="radio"/> Acne	Had Have <input type="radio"/> Hair loss	Had Have <input type="radio"/> Rash	NONE <input type="radio"/>
						Initials _____

Consultation Notes

Doctor's Initials _____

(Continued from previous page)

h. Endocrine

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Thyroid issues ☐ ☐ Immune disorders ☐ ☐ Hypoglycemia ☐ ☐ Frequent infection ☐ ☐ Swollen glands ☐ ☐ Low energy Initials _____

i. Genitourinary

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Kidney stones ☐ ☐ Infertility ☐ ☐ Bedwetting ☐ ☐ Prostate issues ☐ ☐ Erectile dysfunction ☐ ☐ PMS symptoms Initials _____

j. Constitutional

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Fainting ☐ ☐ Low libido ☐ ☐ Poor appetite ☐ ☐ Fatigue ☐ ☐ Sudden weight change ☐ ☐ Weakness Initials _____

Patient name _____

☐ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses

Check the illnesses you have Had in the past or Have now.

Had Have Had Have
☐ ☐ AIDS ☐ ☐ Tuberculosis
☐ ☐ Alcoholism ☐ ☐ Typhoid fever
☐ ☐ Allergies ☐ ☐ Ulcer
☐ ☐ Arteriosclerosis Other: _____
☐ ☐ Cancer _____
☐ ☐ Chicken pox _____
☐ ☐ Diabetes _____
☐ ☐ Epilepsy _____
☐ ☐ Glaucoma _____
☐ ☐ Goiter _____
☐ ☐ Gout _____
☐ ☐ Heart disease _____
☐ ☐ Hepatitis _____
☐ ☐ Malaria _____
☐ ☐ Measles _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ Mumps _____
☐ ☐ Polio _____
☐ ☐ Rheumatic fever _____
☐ ☐ Scarlet fever _____
☐ ☐ Sexually transmitted disease _____
☐ ☐ Stroke _____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

☐ Appendix removal
☐ Bypass surgery
☐ Cancer
Cosmetic surgery
Elective surgery: _____

Eye surgery
Hysterectomy
Pacemaker
Spine _____

Tonsillectomy
Vasectomy
Other: _____

16. Treatments

Check the ones you've received in the Past or are receiving Currently.

Past Currently
☐ ☐ Acupuncture
☐ ☐ Antibiotics
☐ ☐ Birth control pills
☐ ☐ Blood transfusions
☐ ☐ Chemotherapy
☐ ☐ Chiropractic care
☐ ☐ Dialysis
☐ ☐ Herbs
☐ ☐ Homeopathy
☐ ☐ Hormone replacement
☐ ☐ Inhaler
Massages
Physical therapy
Nutritional supplements: _____

List: _____

17. Injuries

Have you ever...

Had a fractured or broken bone Used a crutch or other support
Had a spine or nerve disorder
Been knocked unconscious
Been injured in an accident Had a body piercing

Medications
(prescription and
over-the-counter):

Used neck or back bracing
Received a tattoo

18. Family History

Some health issues are hereditary. Tell Dr. Gomez about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death
		Good	Poor			Natural Illness
Mother	_____					
Father	_____					
Sister	_____	1				
Sister	_____	2				
Brother	_____	1				
Brother 2	_____					

19. Are there any other hereditary health issues that you know about?

20. Social History

Tell Dr. Gomez about your health habits and stress levels.

Alcohol use ☐ Daily ☐ Weekly How much? _____ Prayer or meditation? ☐ Yes ☐ No
Coffee use ☐ Daily ☐ Weekly How much? _____ Job pressure/stress? ☐ Yes ☐ No
Tobacco use ☐ Daily ☐ Weekly How much? _____ Financial peace? ☐ Yes ☐ No
Exercising ☐ Daily ☐ Weekly How much? _____ Vaccinated? ☐ Yes ☐ No
Pain relievers ☐ Daily ☐ Weekly How much? _____ Mercury fillings? ☐ Yes ☐ No
Soft drinks ☐ Daily ☐ Weekly How much? _____ Recreational drugs? ☐ Yes ☐ No
Water intake ☐ Daily ☐ Weekly How much? _____
Hobbies: _____

Doctor's Initials _____

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Doctor's Initials _____

Signature _____

Date (MM/DD/YYYY) _____

Consultation Notes