Andreano Chiropractic

Patient Health Information & Health History

Today's Date: _____

Patient Name: _____ Sex: Male Female

Date of Birth: ____/____/_____ Marital Status: (Circle One) M S D W Other: _____

Spouse Name: _____ How many children: _____

Patient Address: _____

City_____State_____Zip:_____

Patient Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____

Employer: _____ Phone: _____-_____-_____

Occupation: _____ Referred By: _____

Is this condition due to: Auto Accident Personal Injury Work Related Accident

Do you have health insurance? Yes No

Do you have more than one insurance? Yes No

Name of Insurance Company: _____

ID Number: _____

Is your spouse employed? Yes No Is your spouse the primary insured? Yes No

Are you covered by Medicare? Yes No

I authorize Andreano Chiropractic to release medical information to my insurance company:

Signature _____ Date: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

Signature _____ Date: _____

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ISSUES

Primary Issue? _____

Secondary Issue? _____

When did your problem begin? _____

How did your problem begin? _____

Is this problem interfering with your: (Circle all that apply)

Activities of daily living Work Social Activities Hobbies Sleep

Rate your pain: (Circle one— 0 being no pain or 10 being the worst pain)

0 1 2 3 4 5 6 7 8 9 10

Is your health problem worse: (Circle one) Morning Day Evening Night

Does your problem occur: (Circle one)

Occasionally Intermittently Frequently Constantly

Is your problem getting: (Circle one) Better Worse Staying the Same

Have you had this problem before? _____ When? _____

What aggravates your health problem: (Circle all that apply and/or list others) _____

Coughing	Sneezing	Walking
Reaching	Lifting	Bending
Sitting	Lying Down	Standing
Neck Movement		Straining at stool

What relieves your health problem: (Circle all that apply and/or list others) _____

Nothing	Resting	Heat
Sitting	Standing	Ice

Have you had recent treatment for this condition? Yes No

Who did you see? _____

Treatment: _____

Have you had any changes in bowel or bladder habits since your problem began? Yes No

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List your hobbies: 1) _____

2) _____

3) _____

What are your habits?

Smoking	never	packs per day _____
Alcohol	never	drinks per day _____
Caffeinated Drinks	never	drinks per day _____
Exercise	never	times per week _____
Drug/Substance Abuse	never	If yes, discuss it with your doctor

MEDICAL HISTORY

Have you seen a doctor of chiropractic? Yes No

Who is your Family Physician: _____

Date of last physical exam: _____

Do you give us permission to send your family doctor progress & treatment notes? Yes No

Have you been hospitalized in the past five years? Yes No

Date & Reason: _____

Have you had any serious accidents in the past five years: Yes No

Date & Describe: _____

List your medications: _____

In the past 6 months, have you suffered from: (Circle all that apply or circle "Normal")

General:	Fatigue	Weakness	Weight change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision trouble	Dryness	Redness	Cataract Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Coughing	Sneezing	Wheezing	Chest Pain	Palpitations
	Hypertension		Normal		
Gastrointestinal:	Diarrhea	Vomiting	Appetite Change	Heartburn	Constipation
	Gas		Normal		
Endocrine:	Goiter	Sugar in Urine	Heat Intolerance	Cold Intolerance	Normal
Psychologic:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

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Pain Drawing

Name: _____ Date: _____

Date of Birth: _____ Examiner:_____

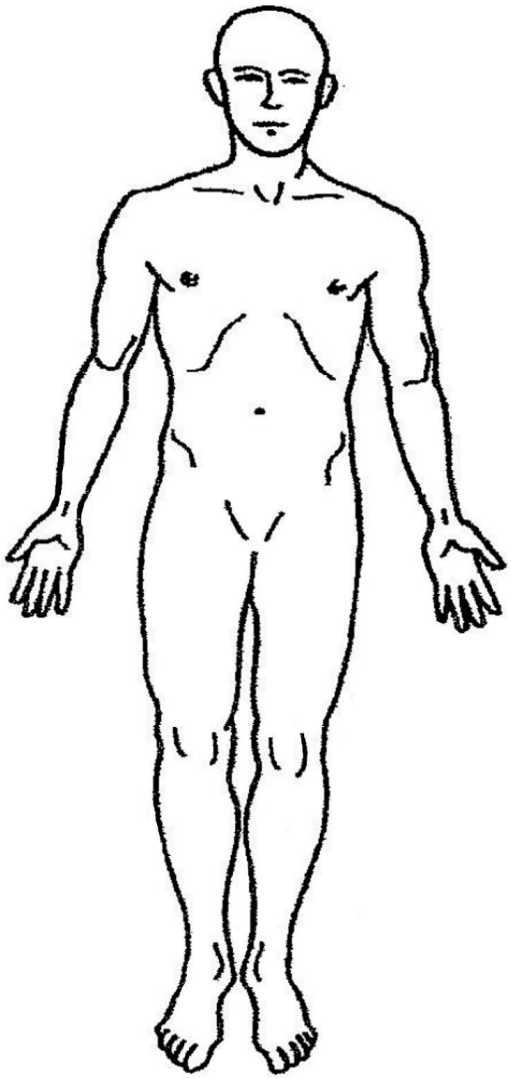
TELL US WHERE YOU HURT.

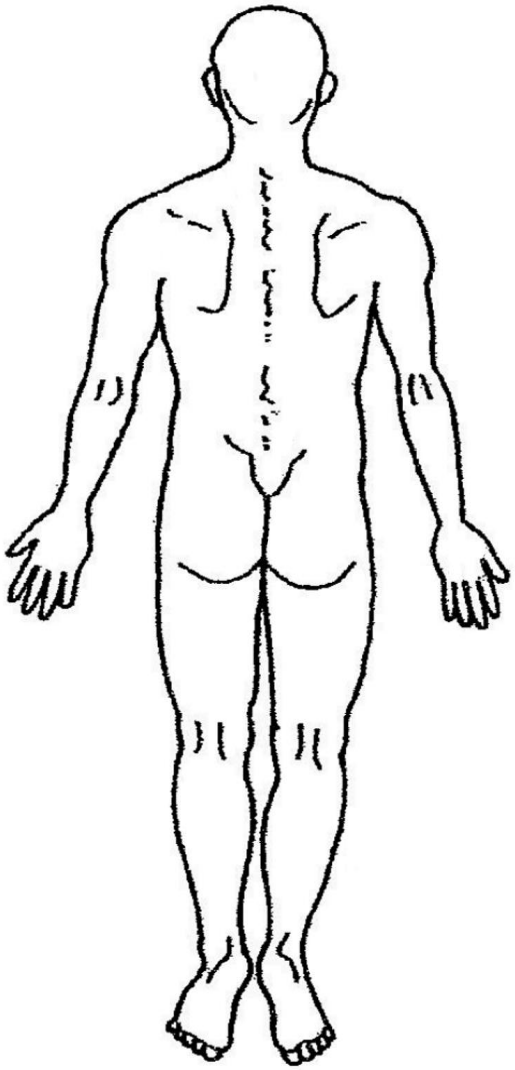
Please read carefully.

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

KEY: Ache: >>>>> Numbness: = = = = = Pins & Needles: o o o o o

Burning: x x x x x Stabbing: / / / / / Throbbing: ~ ~ ~ ~ ~





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INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Andreano Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____