OPTIMAL WELLNESS Chiropractic & Nutrition

Canton Center Chiropractic Clinic

Patient Health History Form

Confidential

Date	Number	X-ray

Patient Information

Name: _____

SS#: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____

Employer: _____

Spouse's Name: _____

Age(s) of Children: _____

Referred By: _____

Insurance

PRIMARY INSURANCE

Insurance Co.: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Relationship to patient: _____

Do you have a Health Spending / Flex Plan: ☐ Yes ☐ No

Do you have a Secondary Insurance: ☐ Yes ☐ No

SECONDARY INSURANCE

Insurance Co.: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Relationship to patient: _____

Phone Numbers

Primary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Cell Carrier: _____ E-Mail: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name of Emergency Contact Person: _____ Relationship to Patient: _____

Primary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Current Health Condition

Primary Complaint: _____

When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No

Rate the Pain from 1 (least pain) to 10 (severe pain): _____ Does the condition occur: ☐ Daily ☐ Weekly ☐ Monthly

Is the persistance of this condition: ☐ Intermittent (0-25% of the time) ☐ Occasional (26-50% of the time) ☐ Frequent (51-75% of the time) ☐ Constant (76-100% of the time)

Please list other doctors you have seen for this condition: _____

Type of Treatment: _____ Results: _____

Is this condition related to: ☐ Work Accident ☐ Auto Accident ☐ Home Injury ☐ Stumble/Fall ☐ Other: _____

Date and Time of Accident: _____

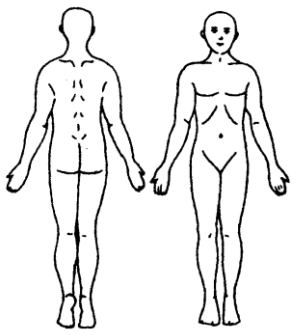
With whom have you filed a report/claim:

☐ Auto Insurance ☐ Employer ☐ Workman's Comp. ☐ None

Please list all Drugs which you currently take: _____

Please list all Supplements which you currently take: _____

List any other health complaints (not listed above): _____



Please outline on the diagram the area of your discomfort

Name	Number

Past Health History Information

Please list any Surgery and/or Operations you have had: _____

_____

Please list all Accidents or Major Falls you have had: _____

_____

Please list any additional Hospitalization (other than above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____

Please Check the following based on your current lifestyle. Do You…

Smoke ☐ Yes ☐ No Packs/day: _____ Consume Caffeine ☐ Rarely ☐ Occasionaly ☐ Frequently

Drink Alcohol ☐ Yes ☐ No Drinks/week: _____ Exercise ☐ Rarely ☐ Occasionaly ☐ Frequently

Do your daily activities include: ☐ Lifting ☐ Bending ☐ Pulling ☐ Sitting ☐ Standing ☐ Heavy Labor ☐ None

Please Check ANY of the following diseases you have had:

☐ Pneumonia	☐ Anemia	☐ Diabetes	☐ Pleurisy	☐ Eczema
☐ Rheumatic Fever	☐ Measles	☐ Cancer	☐ Arthritis	
☐ Polio	☐ Mumps	☐ Heart Disease	☐ Epilepsy	Have you ever been
☐ Tuberculosis	☐ Small Pox	☐ Thyroid	☐ Mental Disorders	tested HIV Positive?
☐ Whooping Cough	☐ Chicken Pox	☐ Influenza	☐ Lumbago	☐ Yes ☐ No

Please Check ANY of the following conditions, if they have occurred in the past 6 months:

MUSCULO-SKELETAL
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm pain
- ☐ Joint Stiffness/Pain
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY
- ☐ Bladder Trouble
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Discolored Urine

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain or Lumps
- ☐ Prostate Problems
- ☐ Sexual Dysfunction
- ☐ Other: _____

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

FAMILY HISTORY

The following members have the same or a similar condition as me:
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

Authorization of Care

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Canton Center Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I request that payment of authorized benefits be made either to me or on my behalf to Canton Center Chiropractic Clinic for any services furnished to me. I understand that any amount authorized to be paid directly to the office will be credited to my account upon 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 hereby authorize the Doctor to treat my condition as he deems appropriate. It is understood and agreed that the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen by appointment while a patient of this office.

I authorize the holder of medical information about me to release to my insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Guardian's Signature of Authorizing Care: _____ Date: _____

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MEDICATION LIST

Patient:_____ DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

ALLERGIES:

Prescription Medications

Name	Dosage	How Often	Reason	Date started	Follow-up Dates			

Over-the-counter Medications

Supplements/Herbs/ Homeopathic Remedies
