HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ MRI, CT-Scan, Bone Scan _____

Family physician's name: _____

Prior chiropractor's name: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia/Bulimia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Type_____ Year_____			Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Other _____		
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Depression	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No						

EXERCISE

Times Per Week _____

Activity _____

DIET

☐ Poor ☐ Average ☐ Good

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____

☐ Alcohol Drinks/Week _____

☐ Coffee/Caffeine Drinks Cups/Day _____

☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

CONFIDENTIAL PATIENT HISTORY

PATIENT INFORMATION

WHO MAY WE THANK FOR REFERRING YOU? _____ Date _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____ email _____

Age_____ Birthdate_____ Sex M F Married ( ) Single ( ) SS# _____

Occupation _____ Employer _____ Business Phone _____

Spouse/Parent Name _____ Employer _____ # Children _____

PATIENT CONDITION

Describe Major Complaint(s) _____

_____

When did it start? _____ Is it getting progressively worse Yes_____ No_____

Have you ever had injuries which gave similar symptoms in the past? Yes_____ No_____

If yes, please explain _____

What percentage of the day are you in pain or discomfort? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Please rate your pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Type of pain: ____sharp ____dull ____throbbing ____numbness aching ____shooting ____Burning ____tingling

____cramps ____stiffness ____swelling ____boring ____heavy, pressing ____other

Do you have any difficulty with: (circle any that apply) bowel – bladder – sexual function – none

How does the pain affect your personality? Please check:

_____ normal, no effect, alert, cheerful

_____ slightly, upset, irritable, complaining

_____ moderately, upset, unhappy, anxious

_____ severely upset, depressed, bitter

_____ totally incapacitated, avoid everyone

Has the pain affected any of the following?

_____ employment

_____ social life

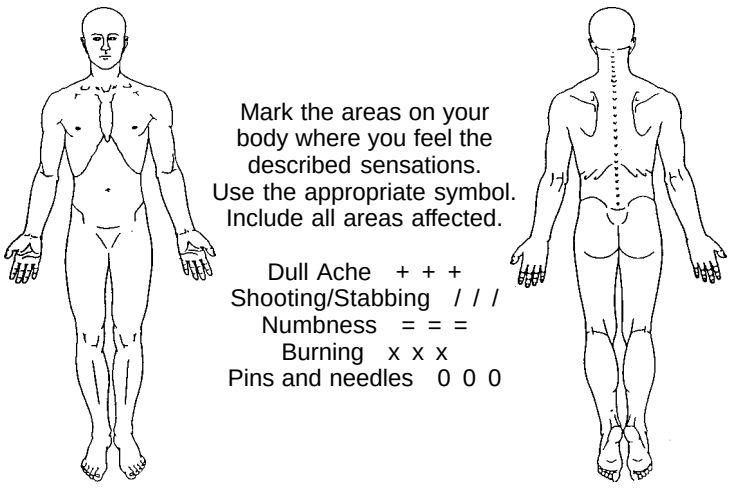
_____ interpersonal relations

_____ specific physical activities

_____ recreational activities

Do you feel this pain: superficial (close to the skin)?_____

or deep (inside body or limb)?_____



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all areas affected.

Dull Ache + + +
Shooting/Stabbing / / /
Numbness = = =
Burning x x x
Pins and needles 0 0 0

PROTECTED HEALTH INFORMATION

Information to Be Disclosed:

- We may post your name on our referral board to thank you for referring a new patient to us. We may also send a thank you card to the person who referred you to our office.
- We may ask if you would like to share how Chiropractic has helped you with a written testimonial. If you accept, we may use it along with your name and picture in promotional activities.
- If you have a child who is a patient here we may ask if you would allow us to post their picture and first name on a bulletin board with other children who are patients here.

Persons Authorized to Use or Disclose Information:

Bradley/Cummings Family Chiropractic, 127-B Marion Blvd, Marion IA

- Information described above may be disclosed to current and new patients and the general public. This authorization is effective for 5 years unless revoked or terminated by the patient. You may revoke or terminate this authorization by submitting a written revocation to Bradley/Cummings Family Chiropractic. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

Signature _____ Date _____