DORLAND CHIROPRACTIC CLINIC

CONFIDENTIAL PATIENT INFORMATION

Dear Patient,

Please complete this questionnaire. This information is a confidential record between your Doctor and you. Illness doesn't just happen, it accumulates. The information below is important to our analysis of your care. We only accept patients that we sincerely feel we can help.

Name _____Ph.#(H)_____(W) _____(C)_____

Address _____City_____ Zip_____

Age____ Birthdate_____ Status M S W D Number of Children_____

Occupation_____Employer Name &City_____

Emergency Name and Phone (office, relatives, etc.)_____

Medical Insurance_____ ID#_____

Email: _____May we add you to our email list? Yes ☐ No☐

Who may we thank for referring you? _____

Please notify receptionist if you have been in an accident or injured.

PRESENT HEALTH CONCERN

Purpose of this appointment (briefly describe symptoms)_____

_____

Possible cause?_____

How long have you had this condition? _____ What aggravates your condition?_____

Have you had this or similar conditions in the past?_____

Is condition getting worse? Yes ☐ No☐ Constant_____

Is condition interfering with work? ___Sleep___ Daily routine?_____

What treatment have you received for this? _____

HEALTH HISTORY

Date of last physical exam_____ Date of last x-rays_____

Family Doctor, Current Medications_____

Surgical operations and dates_____

Previous Chiropractic care? Yes ☐ No☐ When_____ Results_____

Involved in auto accident? Yes☐No☐Year(s)_____

How long has it been since you have really felt good?_____

FAMILY HEALTH HISTORY

Health problems of parents _____

Health problems of children_____

Health problems of spouse_____

HABITS

Sleep (Hrs. per night)_____Sweets (How much) _____Coffee/Tea (Cups per day)_____

Tobacco (How much)_____ Soda Pop (How much)_____ Alcohol (How much)_____

What % of diet is fruits &vegetables_____What % is raw_____

What do you do for exercise?_____

What do you do to rest & recharge?_____

Nutritional supplements taken_____

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK.

GENERAL
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hyperactivity
- ☐ Frequent Colds
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Bruise Easily
- ☐ Allergies
- ☐ Skin Conditions
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Bed Wetting
- ☐ Kidney Problems
- ☐ Prostrate Problems
- ☐ Asthma
- ☐ Sinus Congestion
- ☐ Thyroid Trouble
- ☐ Sore Throats
- ☐ Difficult Swallowing
- ☐ Hiatal Hernia
- ☐ Gall Bladder Trouble
- ☐ Nervousness
- ☐ Irritability
- ☐ Depression
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ General Run down Feeling

HEAD
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Pain in eyes
  - ☐ Headache
  - ☐ Entire head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Light bother eyes
- ☐ Loss of smell

HEADCON'T
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears

NECK
- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sound in neck

SHOULDERS
- ☐ Pain in shoulder joints (R L)
- ☐ Pain across shoulders
- ☐ Bursitis (R L)
- ☐ Can't Raise arm
  - ☐ Above shoulder
  - ☐ Overhead
- ☐ Tension in shoulders
- ☐ Muscle spasm

ABDOMEN
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas Constipation
- ☐ Diarrhea
- ☐ Ulcers

ARMS AND HANDS
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins &needles
  - ☐ in arms
  - ☐ in hands
  - ☐ fingers go to sleep
- ☐ Numbness in fingers
- ☐ Hands cold
- ☐ Loss of grip strength

CHEST
- ☐ Pain around ribs
- ☐ Cough Chest pain

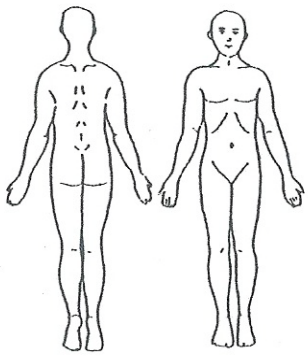
MID-BACK
- ☐ Mid-back pain
- ☐ Muscle spasm

WOMEN ONLY
- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Pregnant?
  - ☐ If not, I'm able to take whatever x-rays may be necessary

LOW BACK
- ☐ Low back pain
- ☐ Low back pain is worse:
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ coughing
  - ☐ lying down
- ☐ Pinched nerves in low back
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle Spasm

HIP, LEGS AND FEET
- ☐ Pain in buttocks (R L)
- ☐ Pain in hip joint (R L)
- ☐ Pain down leg (R L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins/needles in leg (R L)
- ☐ Numbness in legs (R L)
- ☐ Numbness in feet (R L)
- ☐ Feet feel cold
- ☐ Cramps in feet (R L)
- ☐ Swollen ankle/feet (R L)
- ☐ Painful joints in toes

Please mark on the diagram the area of your discomfort



Iunderstand and agree that insurance policies are an arrangement between an insurance carrier and myself. I understand that the Chiropractor's office will prepare the forms to assist me in making collection from the insurance company. However, I understand and agree that all services rendered me are charged directly to me and I am personally responsible for services rendered me will be immediately due and payable.

Patient's Signature_____Date_____

Patient's Guardian/Spouse's
Signature Authorizing Care_____Date_____