

Initial Health Status

Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Occupation: _____ Employer: _____
 Work Address: _____ City: _____ State: _____ Zip: _____
 Spouse Name: _____
 Does your Health Plan offer Chiropractic Benefits: YES / NO / Not Sure
 If YES: Health Plan: _____ Subscriber ID: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

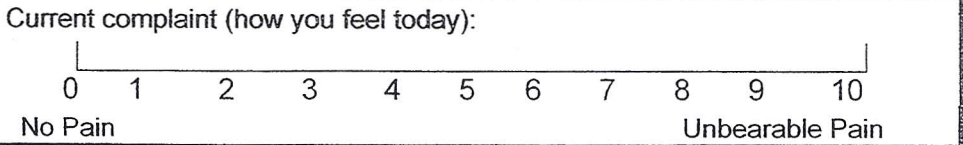
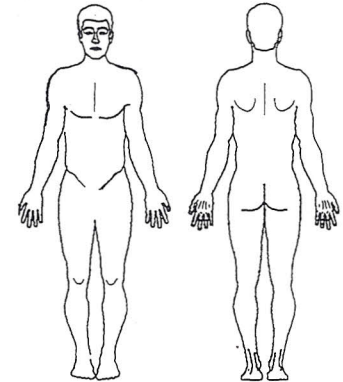
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck pain Mid-back pain Low back pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began: _____

How Problem Began: _____



How often are your symptoms present? 0 – 25% 26 – 50% 51 – 75% 76 – 100%

Can you perform your daily activities? Yes No (Describe any current activity limitations) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN?

Please check all of the following that apply to you: None Apply

- | | | | | | |
|-----------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Condition | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks | <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention | <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Nocturnal Pain (pain at night) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Medications: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

Email: _____