ALL PRO Health Center

PATIENT INFORMATION

Date_____

Name_____

Address_____

City_____ State_____ Zip _____

Home Phone _____ SS#_____

Cell Phone _____ Work Phone_____

Birth Date___/____/____ Age _____ Sex _____

○Married ○Single ○Divorced ○Widowed

Whom may we thank for referring you? _____

May we add you to our email newsletter? Yes No

Email _____

EMPLOYMENT INFO

Occupation_____

Employer _____

Address_____

_____

Phone #_____

EMERGENCY INFO

Contact Name _____

Relationship_____

Phone # _____

Who is responsible for your bill, you and:
○Spouse ○Health Insurance ○Workers' Comp. ○Auto Insurance ○Medicare

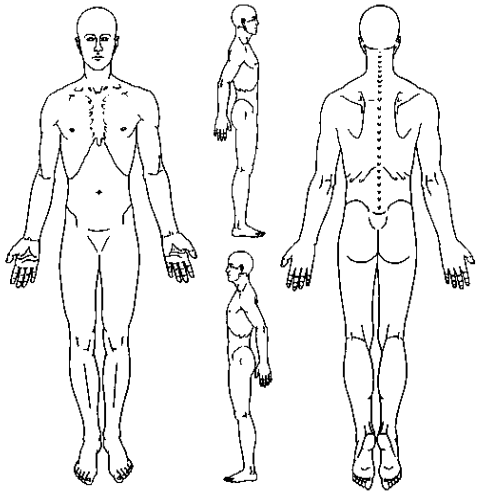
Previous chiropractic care: ○None ○Doctor's name & approximate date of last visit _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

When did the symptoms first appear? _____

[Mark your areas of concern on figure]



Has this condition occurred before? ○Yes ○No

How often do you experience the symptoms?
○Constant 100% ○Frequent 75%
○Intermittent 50% ○Occasional 25% ○Rare 10%

What makes the symptoms worse? _____
What relieves the symptoms? _____

How would you describe the pain?
○Sharp ○Dull ○Aching ○Burning ○Numb
○Throbbing ○Radiating ○Deep ○Other_____

Rate the pain on a scale of 1-10 (10 being unbearable pain):
Right Now 1----2----3----4----5----6----7----8----9----10
At Its Worst 1----2----3----4----5----6----7----8----9----10

Other Doctors Seen For This Condition: ○Yes ○No Who? _____

Type of treatment? _____ Results? _____

Is this condition: ○Job Related ○Auto Accident ○Home Injury ○Fall ○Other:_____

Do you wear a shoe lift? ○Yes ○No

Do you suffer from any condition other than that which you are now consulting us?

_____

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Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

○AIDS/HIV	○Arthritis	○Diabetes	○Gout	○Osteoporosis
○Anemia	○Cancer	○Epilepsy	○Multiple Sclerosis	○Rheumatic Fever

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

Musculoskeletal Code
○General Stiffness
○General Weakness
○Swollen Joints
○Spinal Curvature
○Neck Pain
○Arm Pain
○Pain Between Shoulders
○Low Back Pain
○Foot Trouble
○Walking Problems
○Jaw Problems

Nervous System Code
○Nervous
○Numbness
○Dizziness
○Forgetfulness
○Depression
○Cold/Tingling Extremities
○Stress
○Twitching

General Code
○Fatigue
○Allergies
○Headache
○Loss of Sleep
○Weight Loss
○Fever
○Thyroid Problems

Gastrointestinal Code
○Poor/Excessive Appetite
○Excessive Thirst
○Vomiting
○Nausea
○Diarrhea
○Constipation
○Liver Problems
○Gall Bladder Problems
○Abdominal Cramps
○Gas/Bloating/Belching
○Heartburn
○Black/Bloody Stools
○Colitis

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

EENT Code
○Vision Problems
○Dental Problems
○Sore Throat
○Ear Aches
○Hearing Difficulty
○Stuffed Nose
○Frequent Colds
○Nose Bleeds
○Sinus Trouble
○Hoarseness

Genitourinary Code
○Bladder Trouble
○Painful/Excessive Urine
○Discolored Urine

For Women Only
○Cramps
○Irregular Cycle
○Painful Periods
○Pregnant (now)

Family History
The following members have a same or similar problem as I do:
○Father
○Mother
○Brother
○Sister
○Child
○Other_____

HEALTH HABITS

Exercise/Sports/Hobbies:
1)Type _____ Frequency _____ 2)Type _____ Frequency _____
3)Type _____ Frequency _____ 4)Type _____ Frequency _____

Sleep: Hours/night ___ Sleep quality _____ Do you sleep on your: ○Back ○Side ○Stomach

Smoking/Drinking/Diet: (how much and how often)
Tea/Coffee _____ Liquor/Beer _____ Cigarettes/Tobacco _____

OCCUPATIONAL INFORMATION

Job involves: ○Sitting ○Standing How long? _____

○ Bending ○Stooping ○Twisting ○Turning ○Lifting - How much weight? _____

Physical activity at work: ○Sedentary ○Light manual labor ○Heavy labor

Telephone use at work: ○None ○Moderate ○Heavy ○Traditional receiver ○Headset

Do any work activities aggravate your complaints? _____
_____

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PAST HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type _____ When _____

Type _____ When _____

Type _____ When _____

Please list ALL previous accidents and falls

What _____ When _____

What _____ When _____

What _____ When _____

Please list ALL medications and/or vitamins you take

Name_____ For What_____ Name_____ For What_____

Name_____ For What_____ Name_____ For What_____

Name_____ For What_____ Name_____ For What_____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ *Relief Care*

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

☐ *Corrective Care*

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

☐Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT ○ Cash ○ Check ○ Credit/Debit

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

ANALYSIS: DIAGNOSIS:

Patient Accepted: ○Yes ○No ○Referred Doctor's Signature_____