Bennett Chiropractic and Wellness Center

Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Permanent Address _____

City_____ **State**_____ **Zip Code** _____

Local Address _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

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Continued …

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question (6 characters minimum): _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

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How did you hear about us? (Circle one) ***Advertisement / Sign / Yellow Pages /referral*** _____

Primary reasons for seeking chiropractic care?

1._____ 2._____3._____

Have you been treated by Chiropractor before? Yes No If yes, when? _____

Chief Complaint: _____

Location of complaint: _____

Complaint began when and how? _____

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other_____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? yes/no Where? _____

Grade intensity/severity: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst pain/complaint imaginable)

How frequent is the complaint present, how long does it last?_____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

What do you hope to achieve with Chiropractic care? _____Relief of symptoms only ____Total Corrective Care/Optimal Health

*******All charges are payable on date of service******

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand BENNETT CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collections from the insurance company. I clearly understand and agree that I am personally responsible for payment.

Signature: _____ Date: _____

In case of emergency, Please notify: _____ Phone #:_____

Notice of Disclosure of Protected Health Information

I, _____ have read a copy of Bennett Chiropractic Consent for Use and Disclosure of Protected Health Information. Signature of patient/guardian: _____Date: _____

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HEALTH HISTORY

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

___ Headaches
___ Migraines
___ Joint stiffness/swelling
___ Spasms/cramps
___ Broken/fractured bones
___ Strains/sprains
___ Back. Hip pain
___ Shoulder, neck, arm, hand pain
___ Leg, foot pain
___ Chest, ribs, abdominal pain
___ Problems walking
___ Jaw pain/TMJ
___ Tendonitis
___ Bursitis
___ Arthritis
___ Osteoporosis
___ Scoliosis
___ Bone or joint disease
___ Other:_____

Circulatory and Respiratory

___ Dizziness
___ Shortness of breath
___ Fainting
___ Cold feet or hands
___ Cold sweats
___ Swollen Ankles
___ Pressure sores
___ Varicose veins
___ Blood clots
___ Stroke
___ Heart condition
___ Allergies
___ Sinus problems
___ Asthma
___ High blood pressure
___ Low blood pressure
___ Lymphedema
___ Other:_____

Skin

___ Rashes
___ Allergies
___ Athlete's foot
___ Warts
___ Moles
___ Acne
___ Cosmetic surgery
___ Other: _____

Digestive

___ Nervous stomach
___ Indigestion
___ Constipation
___ Intestinal gas/bloating
___ Diarrhea
___ Diverticulitis
___ Irritable bowel syndrome
___ Crohn's disease
___ Colitis
___ Adaptive aids
___ Other: _____

Nervous System

___ Numbness/tingling
___ Twitching of face
___ Fatigue
___ Chronic pain
___ Sleep disorders
___ Ulcers
___ Paralysis
___ Herpes/shingles
___ Cerebral Palsy
___ Epilepsy/Seizures
___ Chronic fatigue syndrome
___ Multiple sclerosis
___ Muscular dystrophy
___ Parkinson's disease
___ Spinal cord injury
___ Other: _____

Reproductive System

Pregnancy:
___Current___Previous
Date of Last menstrual cycle
_____

___ PMS
___ Menopause
___ Pelvic Inflammatory Disease
___ Endometriosis
___ Hysterectomy
___ Fertilityconcerns
___ prostate problems

Other

___ Loss of appetite
___ Forgetfulness
___ Confusion
___ Depression
___ Difficulty concentrating
___ Drug Use _____
___ Alcohol Use _____
___ Nicotine Use _____
___ Caffiene Use _____
___ Hearing impaired
___ Visually impaired
___ Burning upon urination
___ Bladder infection
___ Eating disorder
___ Diabetes
___ Fibromyalgia
___ Post/Polio syndrome
___ Cancer
Type_____
Date Diagnosed_____

Infectious Disease:

___ HIV
___ TB
___ Hepatitis
___ Other congenital or acquired disabilities
_____

Surgeries_____
Illnesses_____
Accidents/injuries/traumas_____
Family health history _____
Recreational Activities/Hobbies _____
Please list any additional comments regarding your health and well-being:_____
I have read the above information and certify it to be true and accurate to the best of my knowledge.
I authorize this office of Chiropractic to provide me with chirorpactic care in accordance with this state's statutes.

Signature_____ Date_____