CONFIDENTIAL PATIENT HISTORY (Please Print)

Date: _____

Name: _____ Home Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Age:_____ Male Female M S D W Work Phone: (____)_____ Cell Phone: (____) _____

Birth Date: _____ Email: _____

Employer/Job Description: _____ SSN: _____

Nearest Relative & Address (not living with you): _____

Spouse's Name: _____ Have you had previous chiropractic care? _____ When? _____

How were you referred to our office? Google: ___ Insurance site: ___ Yellow Pages: ___ Drive by: ___ Other ___

Other referral name or source: _____

LIST CHIEF COMPLAINTS, IN ORDER OF SEVERITY

1. _____ For How Long? _____
2. _____ For How Long? _____
3. _____ For How Long? _____

How does this affect your daily life? _____

Other doctors consulted for this condition? _____

When did you first notice your present problem? _____

Has it happened before? _____ Date(s) and Treatment(s) _____

When has the most recent aggravation of your condition occurred? _____

Please list all medications, vitamins or treatments you are presently taking: _____

_____

Please list any surgeries that you have had: _____

Please list any accidents/falls you have had (even if they don't seem to contribute to your current condition): _____

_____

Is your present condition work related? Yes ___ No ___ Automobile Accident? Yes ___ No ___

Method of payment? Check ___ Cash ___ Discover ___ MasterCard ___ Visa ___ Are you insured? Yes ___ No ___

Insurance Company Name: _____ Phone #: _____

Insurance Policy # _____ Insured SSN # _____ Group ID # _____

Name of Primary Person on Insurance Plan _____ Insured DOB _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

REVIEW OF SYSTEMS

PATIENT NAME: _____ **DATE:** _____

Please mark the symptoms you have now with an (N), or have had in the past with a (P)

General Symptoms

___ 784.0 Headache
___ 780.6 Fever
___ 780.9 Chills
___ 780.8 Night Sweats
___ 780.2 Fainting
___ 780.4 Dizziness
___ 780.3 Convulsions
___ 780.52 Loss of Sleep
___ 780.7 Fatigue
___ 799.2 Nervousness
___ 783. Weight Loss
___ 782. Numbness/Pain Arms/Legs/Hands
___ 995.3 Allergy (What?)
___ 786.09 Wheezing
___ 729.2 Neuralgia

Gastrointestinal

___ 783. Poor Appetite
___ 536.8 Poor Digestion
___ 994.2 Excessive Hunger
___ 787.3 Belching or Gas
___ 787. Nausea
___ 787. Vomiting
___ 578. Vomiting Blood
___ 536.8 Pain Over Stomach
___ 564. Constipation
___ 558.9 Diarrhea
___ 789. Colon Trouble
___ 455.6 Hemorrhoids
___ 785.1 Liver Trouble
___ 782.4 Jaundice
___ 575.9 Gall Bladder Trouble

Eye, Ear, Nose, Throat

___ 368.9 Poor Vision
___ 378.9 Crossed Eyes
___ 379.91 Pain in Eyes
___ 389.9 Deafness
___ 388.70 Ear Ache
___ 388.30 Ear Noises
___ 388.60 Ear Discharge
___ 478.1 Nasal Obstruction
___ 784.7 Nose Bleeds
___ 462. Sore Throat
___ 784.49 Hoarseness
___ 477.9 Hay Fever
___ 493.9 Asthma
___ 460. Frequent Colds
___ 240.9 Enlarged Thyroid
___ 463. Tonsilitis
___ 686.9 Sinus Problems

Respiratory

___ 786.2 Chronic Cough
___ 786.3 Spitting Blood
___ 933.1 Spitting Phlegm
___ 786.50 Chest Pain
___ 786.09 Difficult Breathing

Genito-Urinary

___ 788.3 Frequent Urination
___ 788.1 Painful Urination
___ 599.7 Blood in Urine
___ 592. KIdney Infection
___ 788.3 Bed Wetting
___ 788.1 Incontinence
___ 601.9 Prostate Trouble

Muscle & Joints

___ Weakness
___ Twitching
___ 847.0 Stiff Neck
___ 722.10 Backache
___ 719. Swollen Joints
___ 781. Tremors
___ 729.5 Foot Problem
___ 724.79 Painful Tailbone
___ 724.5 Pain b/t Shoulder
___ 553.9 Hernia
___ 737.3 Spinal Curvature
___ Low Back Pain

Cardiovascular

___ 783. Rapid Heart
___ 427.89 Slow Heart
___ 401.9 High Blood Press
___ 458.9 Low Blood Press
___ 786.51 Pain over Heart
___ 438. Prev Heart Prob
___ 719.07 Ankle Swelling
___ 459.9 Poor Circulation
___ Vericose Veins
___ Stroke

Skin or Allergies

___ 368.9 Skin Eruptions
___ 698.9 Itching
___ 287.8 Bruise Easily
___ 701.1 Dryness
___ Boils
___ 782.0 Sensitive Skin
___ 708.9 Hives or Allergy
___ 692.9 Eczema
___ On Medications

For Women Only

___ 786.2 Painful Periods
___ 626.2 Excessive Flow
___ 626.4 Irregular Cycles
___ 627.2 Hot Flashes
___ 625.3 Cramps or Backache
___ 634.9 Miscarriage___
___ 623.5 Vaginal Discharge
___ Y___ N Pregnant Now?
Last Pap Date _____
By Who? _____
_____
Birth Control? _____
Last Menstrual Period _____

Habits

___ Smoking ___pks/day
___ Drinking ___/___
___ Coffee ___/day
___ Stress ___ Mild ___ Moderate ___ Severe

Exercise

None ___
Moderate ___
Daily ___

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	___	___	___	___	___
Father	___	___	___	___	___
Brother(s) No. ____	___	___	___	___	___
Sister(s) No. ____	___	___	___	___	___

Have you had any of the following diseases?

___ Appendicitis
___ Pneumonia
___ Rheumatic Fever
___ Polio
___ Tuberculosis
___ Whooping Cough
___ Anemia
___ Measles
___ Mumps
___ Chicken Pox
___ Diabetes
___ Cancer
___ Heart Disease
___ Goiter
___ Influenza
___ Pleurisy
___ Alcoholism
___ HIV/AIDS
___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Lumbago
___ Eczema
___ Gout

Do You feel that you have any nutritional deficiencies? If so, what?_____

Do you desire help with nutritional analysis? ___ Y ___ N

DOCTOR"S NOTES:

San Pedro North Chiropractic Center
1006 CENTRAL PARKWAY SOUTH, SAN ANTONIO, TEXAS 78232 TELEPHONE (210) 490-9169

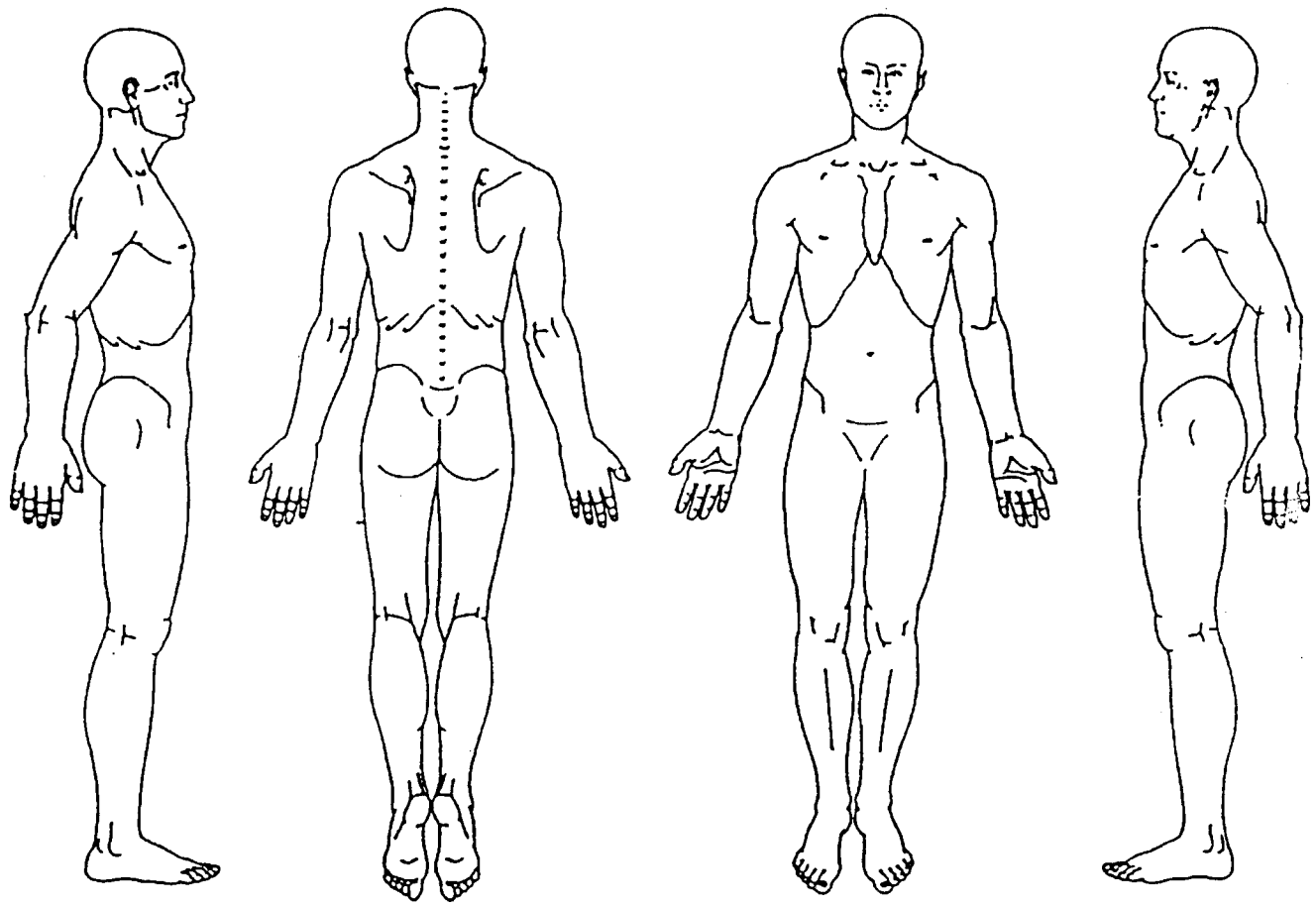
NAME (PRINT): _____

DATE: _____

COMPLAINT: _____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull *N N N*	Stabbing/Cutting /// /// ///	Burning X X X
Numb = = =	Tingling (Pins & Needles) ::::::::	Cramping S S S



PLEASE place one mark on the line below to indicate your present pain level:

No Pain ———————————————————— Worst pain ever

Using the scale of 0-100, with 0 = no pain and 100 = worst possible pain, please write the number indicating your present pain level in the box at the right: