Combined Chiropractic & Acupuncture

Doctor's Confidential Patient Health History

Patient Data Date _____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ Middle Initial ____ Last Name _____

Address: _____

City _____ State _____ Zip Code _____

Cell Phone (_____) _____-_____ Alternative Phone (_____) _____-_____

Cell phone Company_____

(Please Print Clearly) Email _____

Date of Birth _____/_____/_____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other **# of Children and Ages**: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Ethnicity: Not Hispanic or Latino/ Hispanic or Latino/ Other/ Decline Answer **Language:** _____

Race: White (Caucasian)/ Asian/ Black or African American/ American Indian or Alaskan Native/ Hawaiian or Pacific Islander/ Other/ Decline Answer

Smoking Status: Everyday/ Some days/ Former/ Never

Payment/Insurance Information:

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Primary Care Physician: _____ Doctors Phone: _____

Combined Chiropractic & Acupuncture

Doctor's Confidential Patient Health History

PatientName_____Date_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Other _____			

Surgeries: List Type, Date and Reason: None

_____

_____

Allergies (List): _____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Wear Seat Belts:	□ occasional	□ always	□ never

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Please list all current medications being taken: _____

_____

_____

_____

Combined Chiropractic & Acupuncture

Doctor's Confidential Patient Health History

PatientName_____Date_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No
	Past	Present	
Poor Circulation			
Hypertension			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of legs			
Genitourinary			No
	Past	Present	
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stones			
Lower Side Pain			
Neurologic			No
	Past	Present	
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's			
Carpal Tunnel			
Vertigo			
Constitutional			No
	Past	Present	
Weight Loss/Gain			
Low Energy Level			
Difficulty Sleeping			

Respiratory			No
	Past	Present	
Asthma			
Tuberculosis			
Short Breath			
Emphysema			
Cold/Flu			
Cough			
Wheezing			
Eyes			No
	Past	Present	
Glaucoma			
Double Vision			
Blurred Vision			
Psychiatric			No
	Past	Present	
Depression			
Anxiety			
Stress			
Endocrine			No
	Past	Present	
Thyroid			
Diabetes			
Hair Loss			
Menopausal			
Menstrual			
Hematologic			No
	Past	Present	
Hepatitis			
Blood Clots			
Cancer			
Bruising			
Bleeding			
Fever, Chills			
Sweating			

Allergic/Immunologic			No
	Past	Present	
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			
Ear, Nose and Throat			No
	Past	Present	
Difficulty Swallowing			
Dizziness			
Hearing Loss			
Sore Throat			
Nosebleeds			
Bleeding Gums			
Sinus Infections			
Gastrointestinal			No
	Past	Present	
Gall Bladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			
Musculoskeletal			No
	Past	Present	
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Combined Chiropractic & Acupuncture

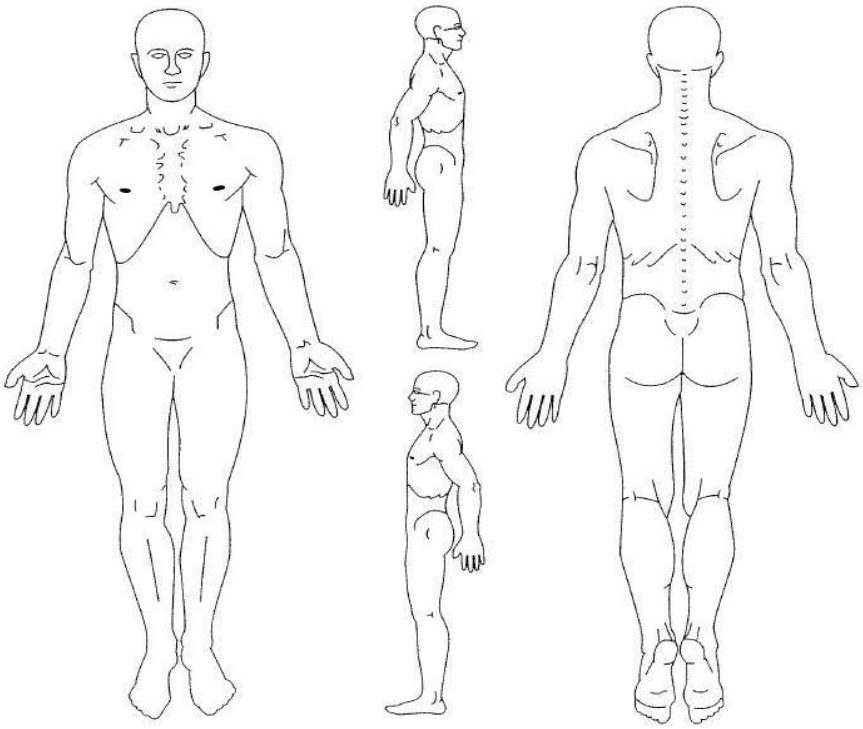
Doctor's Confidential Patient Health History

Patient Name_____Date_____

Are you pregnant? Yes_____ No _____N/A_____ **Please Answer All Questions**

Major Complaint(s): _____

Draw Areas of Complaints:



When did your symptoms begin? _____

Are your symptoms a result of a Motor Vehicle Accident? Yes / No

How did your symptoms begin? _____

Intensity: None (0) Mild(1-2) Mild-Moderate(2-4) Moderate(4-6) Mod-Severe(6-8) Severe(8-10)
Is the Complaint: Sharp/ Stabbing/ burning/ Achy/ Dull/ Stiff & Sore/ pins + Needles/ Numb/ Other:

How are your symptoms changing?
□ Getting better □ Not changing □ Getting worse

I have read the above information and certify it to be true and correct to the best of my knowledge and herby authorize this office to provide me with Chiropractic and Acupuncture care, diagnostic testing, therapeutic services, in accordance with this state's statues.

Patient or Guardian Signature _____ Date: _____

Doctor Signature: _____ Date: _____

Address: 115 Commons Drive Suite D. Mooresville, NC 28117 **Phone:** (980)444-0060 **Email:** CombinedChiropractic@gmail.com