PATIENT DEMOGRAPHIC INFORMATION

EAST CASCADE CHIROPRACTIC

Last name: _____ **First name:** _____ **Middle initial:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home phone: _____ **Cell phone:** _____ **Work phone:** _____

Occupation: _____ **Employer:** _____

Social security number:_____ **Age:** _____ **Date of birth:** _____

Gender: [ ] male [ ] female **Status** [ ] Single [ ] Married [ ] Divorced [ ] Widowed **Height**_____ **Weight**_____

Race: (Circle one) American Indian or Alaska Native/Asian/Black of African American/White (Caucasian)/Native Hawaiian or Pacific Islander/Other/I decline to Answer

Ethnicity: (Circle one) Hispanic or Latino/Not Hispanic or Latino/I decline to answer

CMS requires providers to report both race and ethnicity

Preferred Language:_____

E-mail address:_____

Spouse's name: _____

Spouse's employer: _____

Spouse's work phone: _____

Other nearest relative or contact person: _____ **Phone:** _____

Have you received chiropractic care in the past? [ ] Yes [ ] No

Name of your medical doctor:_____

Complete if applicable to your current condition: [ ] personal injury [ ] auto accident [ ] worker's comp

If you have consulted at attorney regarding the above, please provide your attorney's name, address and phone number:_____

How did you hear about our office? _____

[ ] **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Signature Date

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HEALTH HISTORY

Patient:	Date:	Number:

Do you have any of the following? Mark all that apply.

[ ] Chest pain	[ ] A sore that does not heal	[ ] Pain that wakes you from a sound sleep	[ ] Blurred vision
[ ] Night sweats	[ ] Change in bowel/bladder habits	[ ] Drooping eyelid or change in pupils	[ ] Double vision
[ ] Dizziness	[ ] Unusual bleeding or discharge	[ ] Thickening in breasts or elsewhere	[ ] Nausea or vomiting
[ ] Headaches	[ ] Pain in neck, jaw or face	[ ] A wart or mole that is changing	[ ] Slurred speech
	[ ] Nagging cough or hoarseness	[ ] Ringing in your ears	[ ] Visual disturbances

Please answer the following questions by marking yes or no.

Do you pass out easily or faint?	[ ] Yes [ ] No
Do you take birth control pills?	[ ] Yes [ ] No
Are you pregnant?	[ ] Yes [ ] No
Are you losing weight without trying?	[ ] Yes [ ] No
Are you coughing up blood or noticing it in your stools or urine?	[ ] Yes [ ] No
Have you had any loss of bladder or bowel control?	[ ] Yes [ ] No
Have you lost consciousness or had double vision recently?	[ ] Yes [ ] No
Do you take blood thinners?	[ ] Yes [ ] No

Do you currently have, or have you ever had any of the following? Mark all that apply.

[ ] High blood pressure	[ ] Asthma	[ ] Ulcer or stomach problems	[ ] Thyroid disease
[ ] Heart attack	[ ] Diabetes	[ ] Stroke	[ ] Circulation problems
[ ] Seizures/convulsions	[ ] Kidney disease	[ ] Arthritis	[ ] Cancer
[ ] HIV/AIDS	[ ] Pacemaker	[ ] Mental illness	[ ] Osteoporosis

If female, what was the date of the onset of your last menstrual cycle? _____

Are you currently taking *any* medications (prescription and/or over the counter)? [ ] Yes [ ] No If yes, please list medication, dosage and frequency: _____
_____

Are you seeing any other doctor for any other reason? [ ] Yes [ ] No If yes, please explain: _____
_____

Have you ever had *any* surgeries or hospitalizations? [ ] Yes [ ] No If yes, please list what and date: _____
_____
_____

Have you *ever* had any major traumas, broken bones or fractures? [ ] Yes [ ] No If yes, please list what and date: _____
_____
_____

Do you have any medication allergies or any other allergies: [ ] Yes [ ] No If yes, please list_____
_____
_____

SOCIAL HISTORY

Do you smoke or use tobacco products? [ ] Every Day [ ] Occasional [ ] Former [ ] Never

Do you drink alcohol? [ ] Yes [ ] No If yes, how much? _____

Do you drink coffee? [ ] Yes [ ] No If yes, how much? _____

Do you exercise? [ ] Yes [ ] No If yes, how often? _____

How would you rate your diet? [ ] Poor [ ] Fair [ ] Good [ ] Excellent

FAMILY HISTORY

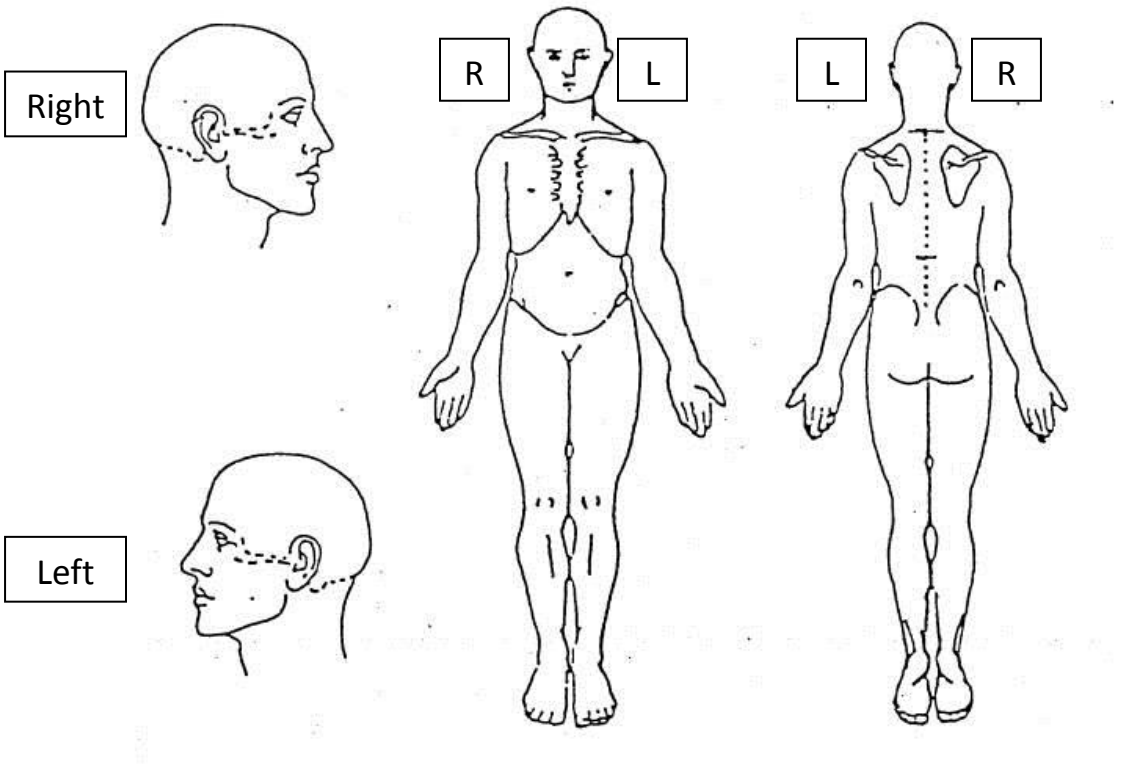
Have your family members (grandparents, parents, siblings, children) had any of the following? Mark all that apply.

[ ] High blood pressure	[ ] Asthma	[ ] Ulcer or stomach problems	[ ] Thyroid disease
[ ] Heart attack	[ ] Diabetes	[ ] Stroke	[ ] Circulation problems
[ ] Seizures/convulsions	[ ] Kidney disease	[ ] Arthritis	[ ] Cancer
[ ] HIV/AIDS	[ ] Pacemaker	[ ] Mental illness	[ ] Osteoporosis

PRESENTING COMPLAINTS

Mark the areas on this diagram where you feel the described sensations. Use the appropriate symbols. Mark all areas of radiation and include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing/Sharp
----------	o o o o o o o	x x x x x x	* * * * * *	/ / / / / / / /
----------	o o o o o o o	x x x x x x	* * * * * *	/ / / / / / / /



On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you've ever felt, please rate the following:

Neck pain: 0 1 2 3 4 5 6 7 8 9 10 **Mid back pain:** 0 1 2 3 4 5 6 7 8 9 10

Low back pain: 0 1 2 3 4 5 6 7 8 9 10 **Other_____:** 0 1 2 3 4 5 6 7 8 9 10

_____

Printed Name Signature Date