HEALTH HISTORY

Please mark the boxes below to indicate Yes (Y) or No (N) if you have had any of the following:

	Y	N		Y	N		Y	N		Y	N
General			Sinus problems			Hepatitis			Arthritis		
Fever/sweats/chills			**Mouth**			High cholesterol			Deformity		
Fatigue			Bleeding gums			Liver disease			Bone pain		
Weight loss/gain			Cold sores			Colonoscopy			Dislocations/fractures		
Sleep disturbance			Trouble swallowing			**G-U System**			**OBGYN**		
Change in routine			Sore throat			Difficulty/painful urinating			Pregnancy		
Mononucleosis			Jaw pain			Blood in urine			Breast Cancer		
Skin			**Lungs**			Incontinence			Miscarriage		
Rash			Difficulty breathing			Foul odor of urine			Lumps in breast		
Bruising			Asthma			Increased/decreased urination			Irregular periods		
Hair loss			Pneumonia/ bronchitis			Urinary infection			Hot Flashes/menopause		
Change in moles			Wheezing			Genital infection			Menstrual cramps		
Neck			Persistent cough			Kidney stones			**Medical**		
Masses			Coughing up blood/phlegm			Kidney disease			Substance abuse		
Swelling			Emphysema			Prostate Cancer			Alcoholism		
Head			Tuberculosis			Prostate problems			Anorexia/bulimia		
Headaches			**Cardio Vascular**			**Psychologic**			Hospitalization		
Dizziness			Chest pain			Excessive stress			Psychiatric Care		
Head trauma			Palpitations			Depression			**Past Medical History**		
Fainting			Ankle swelling			Anxiety			Allergies		
Eyes			Cold/hot feet or hands			Mood swings			Diabetes		
Change in vision			Discolored foot/hand			Suicide attempt			Cancer/tumors/growths		
Glasses/contacts			Leg cramps/calf pain			**Neurologic**			Anemia		
Blurry/double vision			Varicose veins			Seizures/epilepsy			Thyroid problems		
Cataracts			High/low blood pressure			Strokes			Gout		
Sensitive to light			Heart disease			Tingling/numbness			HIV/AIDS		
Flashes/ spots in vision			Pacemaker			Weakness			Prosthesis		
Glaucoma			Bleeding disorder			Difficulty walking			**Family History** (immediate)		
Ears			**G-I System**			Poor coordination			Cancer		
Ringing in ears			Gas			Herniated disk			Alcoholism		
Frequent infections			Heartburn/indigestion			Multiple Sclerosis			Depression		
Hearing loss			Ulcers			Parkinson's disease			Epilepsy		
Drainage			Vomiting/nausea			**Muscle/Bone**			Alzheimer's		
Ear pain			Diarrhea/constipation			Osteoporosis			Heart disease		
Nose			Blood in stool			Joint pain/stiffness			**Other**		
Post nasal drip			Hemorrhoids			Rheumatoid arthritis			_____		
Nosebleeds			Gall bladder disease			Muscle ache/ stiffness			_____		

Descriptions Date

Accidents/Falls/ Head injuries: _____

Broken Bones/Dislocations: _____

Surgeries: _____

MEDICATION INFORMATION

Medications/Supplements Dosage/Frequency (i.e. 5 mg once a day)

_____

_____

_____

_____

_____

Medication Allergies Reaction Onset Date

_____

_____

_____

WELCOME TO MITCHELL CHIROPRACTIC & ACUPUNCTURE CENTER, PC

PATIENT INFORMATION

Date: _____ SSN: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Birthdate: _____ Age _____ ☐ M ☐ F

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ SEPERATED

☐ MINOR ☐ DIVORCED ☐ PARTNERED FOR _____ YRS

Occupation: _____

Employer: _____

Spouse Name: _____

Birthdate: _____ SSN: _____

Spouse Employer: _____

PHONE NUMBERS

Cell Phone: _____

Work/Home Phone: _____

Appointment reminders: EMAIL or PHONE

IN CASE OF EMERGENCY CONTACT

Name & Relationship: _____

Phone Number: _____

Whom may we thank for referring you? _____

I certify that I, and/or my dependents assign directly insurance payments/benefits to Mitchell Chiropractic & Acupuncture Center, PC, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Mitchell Chiropractic & Acupuncture Center may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

☐ I choose to decline receipt of my clinical summary after each visit.

Patient name: _____

Signature: _____

Date: _____

Relation to minor: _____

Do you have a primary care doctor?

__Yes, Doctor name: _____

__I wish to decline to release this information

__No, I do not have a primary care doctor

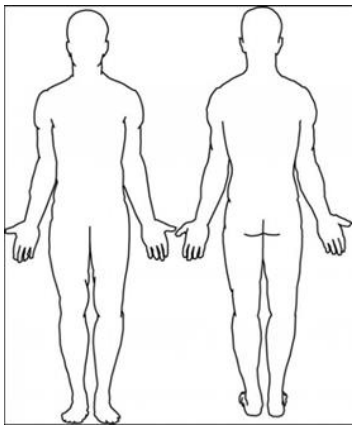
Please circle one for each below

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

Ethnicity: Hispanic or Latino/ Not Hispanic or Latino/ Decline

Preferred Language: _____

PATIENT CONDITION



Reason for visit: _____

When did the symptoms begin? _____

Is this condition getting progressively worse? YES or NO

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Mark an X on the picture where you continue to have pain, numbness, or tingling.

How often do you have this pain (percentage of the day)? _____

Constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down

Are you Pregnant? Yes or No Due Date: _____

Smoking status: Every Day Smoker /Occasional Smoker / Former Smoker / Never Smoked / Decline to Answer **Packs/day:** _____

Exercise: None / Moderate / Daily / Heavy **Work Activity:** Sitting / Standing / Light Labor / Heavy Labor

Alcohol: Drinks/Week: _____ **Coffee/Caffeine:** Cups/Day: _____ **High Stress Level:** Yes or No