

General Information

Name _____ Birth Date ____/____/____ Today's Date ____/____/____
Address _____ City _____ State _____ Zip Code _____
Social Security # _____ - _____ - _____ E-Mail Address _____
Home # () _____ Work # () _____ Cellular # () _____
____ Male ____ Female ____ Single ____ Married ____ Divorced ____ Widowed
Employer _____ Occupation _____
Name of Spouse, Parent or Legal Guardian _____
Names and Ages of Kids _____
Emergency Contact Name _____ Phone # () _____
Insurance Co Name _____ Subscriber Name _____
Subscriber Employer _____ Subscriber Date of Birth _____
Who may we thank for referring you to our office? _____

Your Health Profile

Main reason for consulting our office today? _____

For How Long? _____

What has this problem been keeping you from doing that you really like to do? _____

Is your Condition Caused by ____ Auto Accident? ____ Work Injury? ____ Other? Explain: _____

Is it getting: ____ Worse ____ Improving ____ Staying the Same

Do you have: ____ Pain ____ Numbness ____ Tingling ____ Aches ____ Weakness

Is your pain: ____ Sharp ____ Dull ____ Throbbing ____ Constant ____ Intermittent

Are your symptoms effected by: ____ Sitting ____ Standing ____ Walking ____ Bending

____ Lying Down ____ Weather ____ Other Please explain _____

Do your symptoms interfere with: ____ Work ____ Sleep ____ Day-to-Day Activities ____ Play

____ Other Please Explain _____

Health History

Do you have, or have you had, any of the following (please check all that apply)

- | | | | | |
|------------------------------------|----------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> mumps | <input type="checkbox"/> influenza | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> smallpox |
| <input type="checkbox"/> pleurisy | <input type="checkbox"/> polio | <input type="checkbox"/> chickenpox | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> whooping cough | <input type="checkbox"/> anemia |
| <input type="checkbox"/> eczema | <input type="checkbox"/> measles | <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> rashes |

If you have ever been diagnosed with another disease or condition, please describe _____

Do you use

<input type="checkbox"/> coffee	<input type="checkbox"/> tea	<input type="checkbox"/> artificial sweeteners	<input type="checkbox"/> sugar
<input type="checkbox"/> alcohol	<input type="checkbox"/> cigarettes	<input type="checkbox"/> recreational drugs	

Have you ever suffered from (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> stuffy nose | <input type="checkbox"/> discolored urine |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> allergies | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> headache | <input type="checkbox"/> fainting | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> migraines | <input type="checkbox"/> weight loss | <input type="checkbox"/> colitis |
| <input type="checkbox"/> arm back/tingling | <input type="checkbox"/> poor appetite | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> excessive appetite | <input type="checkbox"/> black or bloody stools |
| <input type="checkbox"/> hand pain/tingling | <input type="checkbox"/> nervousness | <input type="checkbox"/> constipation |
| <input type="checkbox"/> leg pain/tingling | <input type="checkbox"/> confusion | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> depression | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> dental problems | <input type="checkbox"/> stroke |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> frequent nausea | <input type="checkbox"/> tingling |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> vomiting | <input type="checkbox"/> numbness |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> prostate problem | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> breast pain/lump | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> cold extremities | <input type="checkbox"/> cramps | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> painful urination | <input type="checkbox"/> difficulty hearing |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> bladder trouble | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> excessive urination | |

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> falls/accidents | <input type="checkbox"/> head injuries | <input type="checkbox"/> fights |
| <input type="checkbox"/> sports injuries | <input type="checkbox"/> broken bones | <input type="checkbox"/> dislocations |
| <input type="checkbox"/> spinal tap | <input type="checkbox"/> surgery | <input type="checkbox"/> traction |
| <input type="checkbox"/> use(d) a cane or walker | <input type="checkbox"/> excessive dental work | <input type="checkbox"/> dental appliances |
| <input type="checkbox"/> knocked unconscious | | |

If yes to any of the above, please describe _____

Clarifying Your Health Objectives

In addition to the main reason for your visit today, what additional health goals do you have now and in 5 years?

1. _____
2. _____
3. _____
4. _____
5. _____

Are you as healthy (or healthier) today as you were 5 years ago? Yes No Don't Know

If yes, what strategies have you used? _____

Are there any other health concerns that we should be aware of? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible and I assume responsibility for all charges incurred by me.

I hereby direct all payers to release to Sharratt Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize the release of any medical information necessary to process any claims for services incurred by me. I authorize payment of medical benefits to Sharratt Chiropractic for services incurred by me.

X-RAY RELEASE: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

(patient signature)

(date)

I, parent/guardian, give permission for minor's care.

(parent/guardian signature)

(date)

Please Print Name and Relationship to patient _____