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)

☐ pneumonia	☐ mumps	☐ influenza	☐ rheumatic fever	☐ smallpox
☐ pleurisy	☐ polio	☐ chickenpox	☐ thyroid disease	☐ diabetes
☐ epilepsy	☐ cancer	☐ depression	☐ whooping cough	☐ anemia
☐ eczema	☐ measles	☐ arthritis	☐ heart disease	☐ rashes

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

_____

Do you use ☐ coffee ☐ tea ☐ artificial sweeteners ☐ sugar
☐ alcohol ☐ cigarettes ☐ recreational drugs

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

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

If applicable, date of last menstrual period _____

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

☐ falls/accidents	☐ head injuries	☐ fights
☐ sports injuries	☐ broken bones	☐ dislocations
☐ spinal tap	☐ surgery	☐ traction
☐ use(d) a cane or walker	☐ excessive dental work	☐ dental appliances
☐ 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 _____