

CONFIDENTIAL PATIENT INFORMATION

Date _____ SS # _____
 Name _____ Phone # _____
 Local Address _____ City/State/Zip _____
 Other/E-mail Address _____ City/State/Zip _____
 Age _____ Birth Date ____/____/____ Marital Status S M W D How many children _____
 Occupation _____ Employer _____ Work phone # _____
 Work Address _____ City/State/Zip _____
 Name of Spouse _____ Occupation _____ Employer _____
 Work Address _____ City/State/Zip _____ Phone # _____
 Who referred you to our office? _____

List present complaints, injuries and duration and when specifically the symptoms or pain began:

1. _____

2. _____

Brief remarks and details of any recent related accident:

Are symptoms

() getting worse, () getting better, or () staying the same?

List any doctors consulted for present complaints and injuries:

Name _____ Specialty _____

Address _____

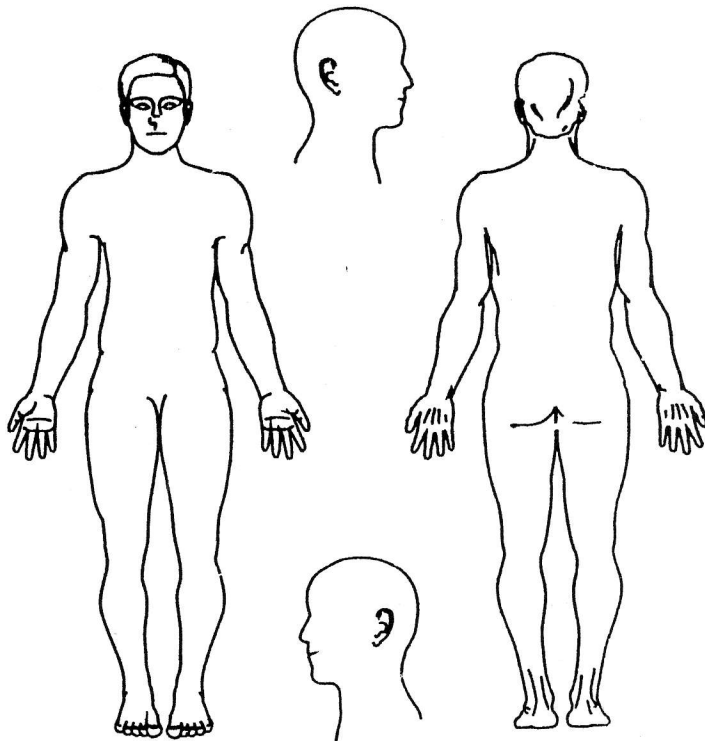
Consulted from _____ to _____

Name _____ Specialty _____

Address _____

Consulted from _____ to _____

Please mark your areas of pain on the figures below



0 _____ 5 _____ 10
 How bad is your pain (circle 0 no pain to 10 unbearable)

Qualls Chiropractic

12020 N. 35th Ave. #102
Phoenix, AZ 85029

PAST HEALTH HISTORY

What surgeries have you had and/or fractures or broken bones, etc?

Type/When/Doctor/Remarks _____

List former serious accidents, injuries and/or falls: (auto, work, home, leisure, other)

What/When/Symptoms/Treatment/Results _____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/How long taken/Remarks _____

Do you wear orthotics, heel or sole lifts, in your shoes? _____

OCCUPATIONAL (PLEASE CIRCLE APPROPRIATE ANSWER & GIVE DETAILS BELOW)

Seated / Standing Work Bench / Desk Counter / Other

Job involves — lifting (how much weight) / bending / stooping / twisting / turning / carrying / walking / standing / other

Chair — Executive / Steno / Bench / Stool / Folding / Other _____

Shoes — High heels / boots / other _____

Do any work activities aggravate present main complaints? (describe) _____

Comments _____

LEISURE

Sedentary activities — TV/reading/card games/sewing/other (circle all applicable & describe how long) _____

Strenuous activities — Sports/exercise (type, frequency, length of time) Have you had to discontinue any activities?
describe _____

How would you grade your general stress level?

No stress Minimal stress Moderate stress Greatly stressed

Physical activity at work

sedentary more than 50% of workday light manual labor manual labor heavy manual labor

General physical activity

no regular program light exercise program strenuous exercise program

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

signed: _____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

signed _____ (Parent / Legal Guardian)

UNDERSTAND and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian or Spouse's signature _____ Date _____

Information taken by _____ Date _____

Please **circle** current conditions - (✓) check former conditions
 *(Please give details on any marked areas at the bottom of the page.)

GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Gain/Loss of Weight
- Numbness/pain in arms, hands, legs
- Allergy
- Wheezing
- Neuralgia/neuritis
- Depression

E.E.N.T.

- Failing vision
- Near sightedness
- Far sightedness
- Crossed eyes
- Eye pain
- Deafness
- Earache
- Ear discharge
- Nose bleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- Appendicitis
- Scarlet fever
- Diphtheria
- Typhoid fever
- Pneumonia
- Rheumatic fever
- Polio
- Malaria

E.E.N.T. continued

- Tinnitus
- Asthma
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands

SKIN

- Skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Hives or allergy

RESPIRATORY

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing

CARDIOVASCULAR

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure

CARDIOVASCULAR cont'd

- Pain over heart
- Previous heart attack
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Aneurysm

MUSCLE & JOINT

- Stiff neck
- Backache
- Swollen joints
- Painful tailbone
- Foot trouble
- Pain in shoulders
- Hernia
- Spinal curvature
- Faulty posture
- Arthritis

GENITOURINARY

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection
- Kidney stones
- Bed wetting
- Inability to control urine
- Prostate trouble

GASTROINTESTINAL

- Poor appetite
- Difficult digestion
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Vomiting of blood
- Pain over stomach
- Constipation
- Colon trouble
- Hemorrhoids (piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

FOR WOMEN ONLY

- Painful menstruation
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Lumps in breast
- Menopausal symptoms
- Pregnancy

- Diabetes
- Cancer
- Heart disease
- Goiter
- Influenza
- Pleurisy
- Alcoholism
- Venereal infection

- Epilepsy
- Mental disorder
- Eczema
- Drug dependency
- Emphysema
- Asthma
- H.I.V.
- AIDS
- _____

Coffee, tea, caffeinated soft drinks (cups per day) _____ Tobacco (packs per day) _____

DO YOU HAVE A PERMANENT DISABILITY RATING? _____ Location _____ Date received _____
 rating percentage _____

COMMENTS: _____

