EFFECTIVE INTEGRATIVE HEALTHCARE, LLC

EFFECTIVE CHIROPRACTIC Health and Wellness Center

Health History Form

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Home #: _____ Cell: _____ Work: _____ **Email Address:** _____

Occupation: _____ Employer: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Last Visit? _____

Have You Ever Received Physical Therapy? ☐ Yes ☐ No Last Visit? _____

REFERRALS

How Did You Hear About This Office?

☐ Existing Patient: _____
☐ Walk-In/Drive-By
☐ Your Health Magazine
☐ Provider Referral: _____
☐ Marketing Event: _____
☐ Insurance Company: _____
☐ Attorney: _____
☐ Internet: _____
☐ Ad: _____
☐ Community Event: _____
☐ Other: _____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Effective Integrative Healthcare, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient/Responsible Party Signature: _____

Patient/Responsible Party Print: _____

Date: _____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain	☐ Tension Across Top of Shoulders	☐ Tired/Fatigued
☐ Pain between Shoulder Blades	☐ Numbness/Tingling in Arms/Hands	☐ Difficulty Sleeping
☐ Neck Pain	☐ Numbness/Tingling in Legs/Feet	☐ Allergies
☐ Tension/Headaches	☐ Pain in the legs	☐ Digestive Problems
☐ Fibromyalgia	☐ Pain in the feet	☐ Carpal Tunnel

OTHER (explain) _____

Have you had any accidents within the past year that affected your symptoms? ☐Auto ☐Slip/Fall ☐Other ☐NONE

Which of the above is the worst? 1._____ 2._____ 3._____ 4._____

How would you rate the level of discomfort right now on a scale of 1 to 10? (10 is the worst pain) _____

How long have you had it? _____ Specific Injury: _____ Over time? _____

How frequently do you feel the discomfort?(Circle one) 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What makes the pain worse? (Circle all that apply)
Bending, cleaning, cooking, coughing, dressing, driving, exercising, kneeling, lifting, lying, pulling, pushing, reaching, running, sitting, standing, sneezing, turning, typing, walking, working, other: _____

What makes the pain better? _____

Do you feel like this condition is getting worse? YES NO UNSURE

What does this pain feel like? (Circle all that apply)
Sharp Dull Burns Shooting Crushing Throbbing Achy Stiff Numb Tingling Other: _____

Does the pain move or radiate? YES NO If YES, describe: _____

Does the pain stop you from, or reduce, your ability to do any of your normal activities? YES NO
If YES, describe: SLEEP, WORK, RECREATION, DAILY, ROUTINE, OTHER: _____

TIMING: Is the pain: (Circle all that apply) CONSTANT, BETTER IN AM, INTERMITTENT, WORSE IN AM, WORSE IN PM

Has the pain ever occurred before? YES NO Number of times per week you have this problem _____

Have you seen other Doctors for THIS condition? YES NO

If yes. Name of Doctor(s): _____ Results: _____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
☐ Moody	☐ Decision making	☐ Lose patience with spouse/children
☐ Irritable	☐ Poor attitude	☐ Restricted household duties
☐ Interrupt sleep	☐ Decreased productivity	☐ Hinders ability to exercise or sports
☐ Restricted in your daily activities	☐ Exhausted at the end of the day	☐ Interferes with ability to do hobbies or other activities
	☐ Unable to work long hours	

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

◆ Medications... Helped: Little Some Much	◆ Exercise... Helped: Little Some Much
◆ Physical Therapy...Helped: Little Some Much	◆ Nutrition... Helped: Little Some Much
◆ Chiropractic... Helped: Little Some Much	◆ Stretching... Helped: Little Some Much

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Night Pain
- ❑ Depression
- ❑ Cold Extremities
- ❑ Nervousness
- ❑ Sleeping Difficulties
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Nausea
- ❑ Loss of Taste
- ❑ Fatigue
- ❑ Chest Pain
- ❑ Tension
- ❑ Loss of Smell
- ❑ Fainting
- ❑ Dizziness
- ❑ Stomach Problems
- ❑ Asthma
- ❑ Swollen Joints
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Cold Sweats
- ❑ Constipation/Diarrhea
- ❑ Allergies
- ❑ Shortness of Breath
- ❑ Blurred/Double Vision
- ❑ Bowel/Bladder Changes
- ❑ Trouble Concentrating
- ❑ Loss of Balance

Please check if you have ever had any of the following:

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Bad Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Trouble
- ❑ Contacts/Glasses
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other: _____
_____
_____
_____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_____ ❑ Diabetes _____ ❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

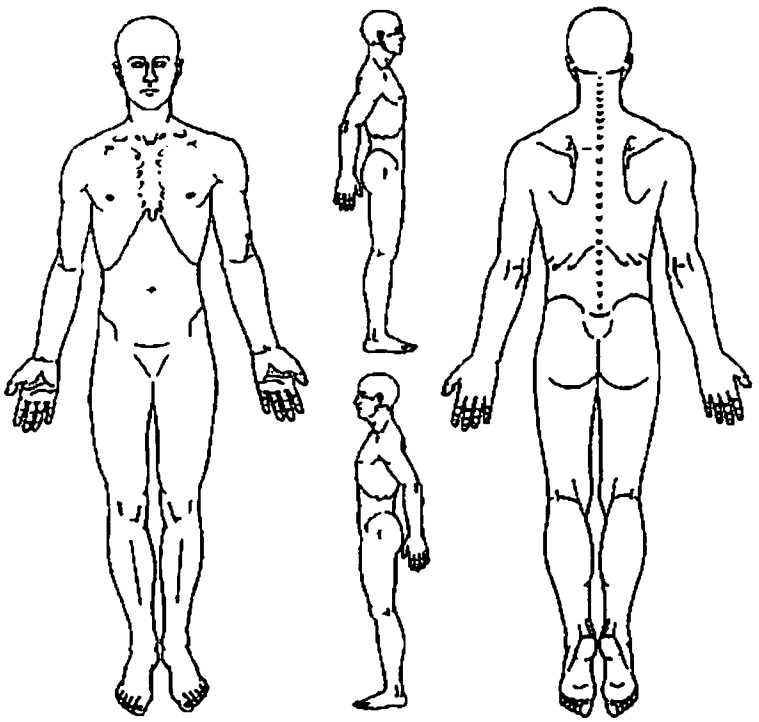
What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol __ drinks/week Cigarettes _____ packs/day

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

___ __Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
_____Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine ___Mildew
___Mold ___ ___Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander ___Cat
Dander ___Latex _____Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____



Mark areas of pain on the figure.
No Pain = 0 Worse = 10

PAIN CHART
Type of Pain: STIFFNESS BURNING
NUMB/TINGLING SHARP
SORENESS/ACHY

NECK PAIN
0 1 2 3 4 5 6 7 8 9 10
SHOULDER/ARM 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
HIP/LEG PAIN
0 1 2 3 4 5 6 7 8 9 10
FOOT/ANKLE PAIN
0 1 2 3 4 5 6 7 8 9 10
HEADACHE PAIN
0 1 2 3 4 5 6 7 8 9 10
OTHER PAIN:_____
0 1 2 3 4 5 6 7 8 9 10

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health, I will give complete and accurate information during my exam.

Print Name: _____

SIGNATURE (X) _____ **DATE:**_____

X-ray Questionnaire: For women only
Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____
_____

Date of last menstrual period: _____

_____ _____
Patient's Signature Date