Capitol Chiropractic Health Center
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Patient Information

Date: _____

Patient Name: _____
(First, Middle, Last)

Age: _____ Date of Birth: _____

Name by Which You Wish to be Addressed: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone #: _____ Cell Phone #: _____

Social Security Number: _____ Driver's License Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed E-mail Address: _____

Primary Care Physician's Name: _____ Date of Last Physical Exam: _____

How were you referred to the office? ☐ By a Physician ☐ Yellow Pages ☐ Lecture ☐ Exhibit ☐ By a Patient

Please print the name of reference source _____

Are you a FitClub Member? ☐ Yes ☐ No

Insurance Carrier: _____ Group #: _____

Employment Information

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student ☐ Other _____

Employer: _____ Occupation: _____

Address: _____ Phone #: _____

Spouse Information

Spouse Name: _____ Date of Birth: _____

Occupation: _____ Employer: _____ Phone #: _____

Person Responsible for Payment (if other than Patient)

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____ Phone #: _____

Emergency Contact Person

Name: _____ Phone #: _____ Relationship to Patient: _____

Past Health History

Hospitalizations - please list any and all hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Surgeries - please list any and all surgeries

Type	Age Performed	Date Performed	Place of Surgery (area of body) and Physician	Left/Right or Bilateral

Injuries - please list any and all injuries

Year	Description of Injury and Areas injured

Smoking Status

☐ Current Every Day Smoker ☐ Current Periodic Smoker: How often _____
☐ Former Smoker: Year started_____ Year Quit _____ ☐ Never Smoker
☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Lives with Smoker

Type and Quality of Tobacco

☐ Chews Number of pouches per week? _____
☐ Cigarettes Number of packs/day? _____
☐ Cigars Number per week?_____
☐ Dips Cans per week? _____
☐ Pipe Number of Pipefuls per day? _____

Present Complaints

1. Chief Complaint and Location:_____

How did this occur: ☐ Injury at work ☐ Auto Accident ☐ Accident (Fall, etc.)
☐ Other, Please describe: _____
Date of injury and/or onset of symptoms: _____
Does your pain radiate (travel) or is it localized? If it radiates, please describe where it travels from and to._____
Does your pain occur at work, home, during exercise, AM, PM, etc.? _____
Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 0 1 2 3 4 5 6 7 8 9 10
Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of time it occurs. _____
Have your symptoms gotten better, stayed the same, or gotten worse? _____
What treatments have you tried yourself for this condition? Have they helped or made your pain worse? _____

2. Second Complaint and Location:_____

How did this occur: ☐ Injury at work ☐ Auto Accident ☐ Accident (Fall, etc.)
☐ Other, Please describe: _____
Date of injury and/or onset of symptoms: _____
Does your pain radiate (travel) or is it localized? If it radiates, please describe where it travels from and to._____
Does your pain occur at work, home, during exercise, AM, PM, etc.?_____
Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 1 2 3 4 5 6 7 8 9 10
Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of time it occurs. _____
Have your symptoms gotten better, stayed the same, or gotten worse? _____
What treatments have you tried yourself for this condition? Have they helped or made your pain worse? _____

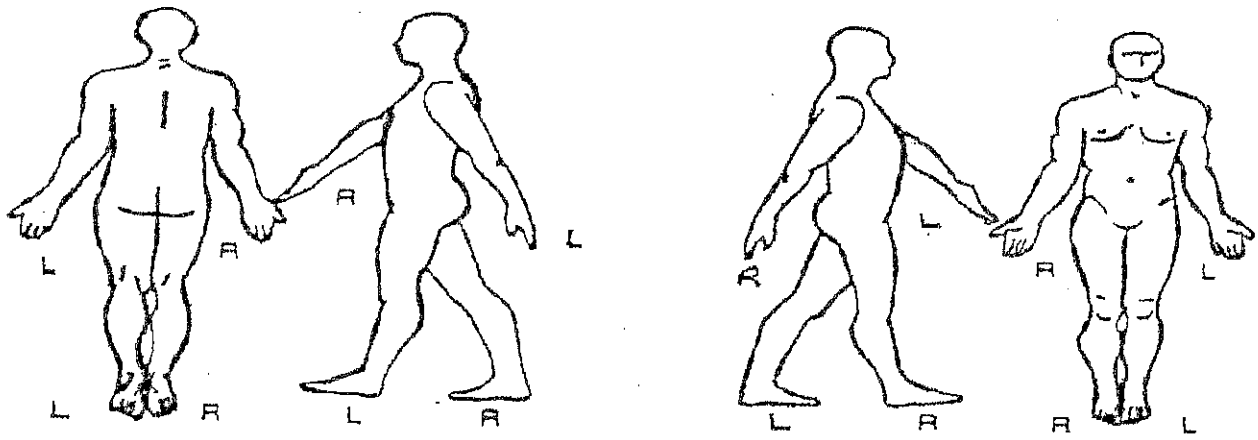
Previous Treatment of above Complaint(s)

1. Physician Name: _____ Type of Physician:_____
Date(s) of Visit (s) :_____ Diagnosis: _____
Type of Treatment :_____ Result of Treatment: _____
2. Physician Name: _____ Type of Physician:_____
Date(s) of Visit (s): _____ Diagnosis: _____
Type of Treatment: _____ Result of Treatment: _____
3. Physician Name: _____ Type of Physician:_____
Date(s) of Visit (s): _____ Diagnosis: _____
Type of Treatment: _____ Result of Treatment: _____

A=Ache B=Burning D=Dull I=Itching N=Numbness P=Pins & Needles S=Stabbing SH=Sharp

T=Tender TH= Throbbing TT= Tightness O=Other_____

Use the above letters to indicate type and location of pain, discomfort and sensations.



In reference to the following descriptions, check the appropriate box as to what activities increase or decrease your symptoms

	Increase	Decrease		Increase	Decrease
With a Cough/Sneeze	☐	☐	Lying flat on Back	☐	☐
Sitting Down	☐	☐	Lying on Stomach	☐	☐
Driving an Automobile	☐	☐	Lying on Side w/ knees bent	☐	☐
Bending over to Brush Teeth	☐	☐	Strain w/ Bowel Movement	☐	☐
Walking	☐	☐	Upon awakening	☐	☐
At the End of the Day	☐	☐	Middle of the Night	☐	☐

Please list any other activities, etc. which increase or decrease your symptoms not listed above._____

_____

_____

Medications - List any and all medications you are presently taking

Name of Medication	Dosage	Times Per Day	Reason for Taking

Vitamins/Supplements - List any and all vitamins/supplements you are presently taking

Name of Vitamin/Supplement	Dosage	Times per Day	Reason for Taking

Allergies: (Medications, food, other)	Type of Reaction

REVIEW OF SYSTEMS

The items below may relate to your current condition. In the space in front of each item, place a "C" if you CURRENTLY have the problem and an "P" if you HAD the problem in the past. Leave space blank if you NEVER had the problem.

GENERAL

1. _____ Fever
2. _____ Chills
3. _____ Night Sweats
4. _____ Loss of Sleep/Insomnia
5. _____ Fatigue
6. _____ Nervousness
7. _____ Weight Loss or Gain
8. _____ Allergies
9. _____ Bleeding Problems
10. _____ Anemia
11. _____ Diabetes
12. _____ Cancer
13. _____ Depression
14. _____ Alcoholism
15. _____ Anorexia
16. _____ Bulimia
17. _____ Bronchitis
18. _____ Cataracts
19. _____ Emphysema
20. _____ Water Retention
21. _____ Glaucoma
22. _____ Goiter
23. _____ Gout
24. _____ Hepatitis
25. _____ High Cholesterol
26. _____ Measles
27. _____ Migraine Headaches
28. _____ Mononucleosis
29. _____ Multiple Sclerosis
30. _____ Mumps
31. _____ Polio
32. _____ Rheumatic Fever
33. _____ Scarlet Fever
34. _____ Thyroid Problems
35. _____ Typhoid fever
36. _____ Chronic Fatigue Syndrome
37. _____ Cold Sores
38. _____ Diphtheria
39. _____ Lupus
40. _____ Malaria
41. _____ Pleurisy
42. _____ Whooping Cough
43. _____ Chicken Pox

WOMEN ONLY

44. _____ Live Births #_____
45. _____ Miscarriage # _____
46. _____ Hot Flashes
47. _____ Painful Periods
48. _____ Excessive Flow
49. _____ Irregular Cycles
50. _____ Vaginal Burning/Itching
51. Date Last Period: _____
52. Date Last Mammogram: _____
53. Birth Control Type: _____
54. Date of Last Pap: _____

MEN ONLY

55. _____ Testicular Pain/Swelling
56. _____ Prostate Problems

RESPIRATORY

57. _____ Difficulty Breathing
58. _____ Chronic Cough
59. _____ Spitting Phlegm
60. _____ Spitting Blood
61. _____ Wheezing/Asthma
62. _____ Pneumonia
63. _____ Tuberculosis

CARDIOVASCULAR

64. _____ Irreg. Heartbeat Rapid or Slow
65. _____ High/ Low Blood Pressure
66. _____ Pain Over Heart
67. _____ Previous Heart Trouble
68. _____ Ankle Swelling
69. _____ Varicose Veins
70. _____ Rheumatic Fever
71. _____ Stroke
72. _____ Heart Attack
73. _____ Poor Circulation
74. _____ Pacemaker/Defibrillator
75. _____ Arteriosclerosis

GENITO-URINARY

76. _____ Frequent Urination
77. _____ Painful Urination
78. _____ Blood in Urine
79. _____ Kidney Infection
80. _____ Kidney Disease
81. _____ Urinary Infection
82. _____ Inability to Control Urination
83. _____ Difficulty Starting Urine Flow
84. _____ Get up ___ times/ night to urinate
85. _____ Breast Lump or Pain
86. _____ Sexual Difficulties
87. _____ Bedwetting
88. _____ Venereal Infection/Disease
    Type_____
89. _____ Vaginal Infections

SKIN

90. _____ Itching
91. _____ Bruising Easily
92. _____ Change in Mole(s)
93. _____ Skin Cancer
94. _____ Dry Skin
95. _____ Eczema
96. _____ Psoriasis
97. _____ Scars/Location _____
98. _____ Rash or Hives

NEUROLOGIC

99. _____ Weakness
100. _____ Twitching
101. _____ Tremors
102. _____ Headache
103. _____ Fainting
104. _____ Dizziness
105. _____ Convulsions
106. _____ Epilepsy
107. _____ Numbness/Tingling
108. _____ Arm/Leg Pain
109. _____ Mental Disorder

MUSCULOSKELETAL

110. _____ Neck Stiffness/Pain
111. _____ Pain Between Shoulders
112. _____ Low Back Pain
113. _____ Swollen Joints/Bursitis
114. _____ Painful Joints
115. _____ Muscle Aches/Soreness
116. _____ Spinal Curvature
117. _____ Osteoarthritis
118. _____ Rheumatoid Arthritis

EYE, EAR, NOSE, THROAT

119. _____ Hoarseness
120. _____ Poor Vison/Failing
121. _____ Pain in Eye(s)
122. _____ Gum Problems
123. _____ Nosebleeds
124. _____ Nose Problems
125. _____ Sinus Trouble
126. _____ Dental Problems
127. _____ Tonsilitis
128. _____ Tonsillectomy
129. _____ Deafness/Difficulty Hearing
130. _____ Ringing in Ears
131. _____ Sore Throat
132. _____ Swollen/Enlarg.Glands

GASTROINTESTINAL

133. _____ Leaky Gut Syndrome
134. _____ Heartburn
135. _____ Poor Appetite
136. _____ Poor Digest./Indigestion
137. _____ Difficulty Swallowing
138. _____ Belching or Gas
139. _____ Frequent Nausea
140. _____ Vomiting w/wo Blood
141. _____ Pain Over Abdomen
142. _____ Ulcer
143. _____ Black or Bloody Stools
144. _____ Liver Problems
145. _____ Gall Bladder Problems
146. _____ Jaundice
147. _____ Hernia
148. _____ Diarrhea
149. _____ Constipation
150. _____ Hemorrhoids
151. _____ Appendicitis
152. _____ Excessive Thirst
153. _____ Acid Reflux

HABITS

154. _____ Alcohol ____ #drinks/Day
155. _____ Recreational Drug Use
156. _____ Tobacco/Smoking ___#pks/Day
157. _____ Sugar/Substitutes _____ amt./Day
158. ____ Caffeinated Drinks
    #_____Cups/Day
    #_____Cans/Day

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

CONDITION	FATHER Age ___	MOTHER Age ___	SPOUSE Age ___	BROTHER (S) Age ___ Age ___		SISTER (S) Age ___ Age ___		CHILDREN Age ___ Age ___	
Allergies									
Arthritis									
Asthma-hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc problem									
Emotional Problems									
Emphysema									
Epilepsy									
Gastrointestinal disorders									
Headaches									
Heart Disease									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Disease									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Syphilis									
Other									
Other									
Other									

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

Consent to Treatment

I voluntarily consent to receive chiropractic and health care services that may include diagnostic procedures, examinations and treatment.

Our doctors will discuss your health history, perform an examination and discuss recommendations with you. They only accept cases based on examination findings and diagnostic tests. There are no guarantees or promises of improvement or complete recovery. We will ask you many questions pertaining to your health, pain, and present condition. Please give the doctor as much information as you can remember.

Your signature below fully authorizes our staff and doctors to perform any examination, diagnostic test and or treatment we may consider medically necessary, and to release all information pertinent to your health, insurance, or benefits to any and all applicable parties on your behalf.

Financial Responsibility and Assignment of Benefits

I agree to pay all services and or fees accrued on my account, including but not limited to chiropractic services, supplements, supplies, missed appointment fees, service charges and/or collection fees.

I certify that I have read this form and understand its content.

_____ Date: _____

(Patient Signature or Other Legally Authorized Person)

Information Checked/Witnessed By: _____ Date: _____