PATIENT INFORMATION AND HEALTH HISTORY

Date: _____ Name: _____

Age: _____ Date of Birth: _____ Sex: M F *Preferred Language:_____

Address: _____ City/St: _____ Zip: _____

Home Phone # : _____ Cell Phone # : _____ E-Mail: _____

Marital Status: S M D W Spouse's Name: _____ Children? Y N

If yes, how many? _____ Names and Ages: _____

Emergency Contact: _____ Phone No.: _____

*Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)/ Native Hawaiian or Pacific Islander / Other / I Decline to Answer

*Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Employed? Y N If yes, Employer's Name: _____

Work Address: _____ Phone: _____

Occupation: _____ May we contact you at work, if necessary? Y N

Primary Care Physician: _____

Location: _____ Phone # : _____

Who referred you to our office? Patient: _____ Doctor: _____

Attorney: _____ Other: _____

For what conditions are you consulting Dr. Schagen? _____

Is condition due to: 1. Auto Accident? Y N 2. Work Injury? Y N 3. Other Accident? Y N 4. Illness? Y N

Just Developed? (please explain): _____

Please mark the type of care you desire so that we may be guided by your wishes.

1. Regular care for Health, Maintenance and Prevention: _____ 2. Control of immediate problem: _____

3. Temporary Relief: _____ 4. I prefer Dr. Schagen to select the type of care most indicated by my condition: _____

When did symptoms begin? _____ When was the most recent flare up? _____

What do you believe caused the symptoms to appear? _____

Have the symptoms improved? Y N Worsened? Y N Have you had similar symptoms? Y N

If yes, when? _____ Why? _____

Have you ever been under chiropractic care? Y N If yes, when? _____ Where? _____

Who provided treatment? _____ Why? _____

Have you had surgery? Y N If yes, when? _____ Why? _____

Please list the amounts of the following engaged in daily: Coffee (# of cups) ___ White sugar (# of tsps.) ___ Water (# of glasses) ___

Alcohol (how much of what type) _____

*Smoking Status (Circle one): Every Day Smoker / Occasional Smoker: Date started smoking _____ Former Smoker / Never Smoked

Average # of sleeping hours: ____ List any regular exercise engaged in: _____

*Are you currently taking any Medications, Vitamins, or Supplements? (Please include regularly used over the counter medications)

Medication, Vitamins, Supplements Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

*Do you have any Medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Other Allergies?

Other Allergies	Reaction	Onset Date	Additional Comments

PLEASE CHECK ANY SYMPTOMS YOU NOW HAVE

GENERAL

( ) Convulsions
( ) Dizziness or Fainting
( ) Headaches
( ) Numbness

CARDIO-VASCULAR

( ) Rapid Heartbeat
( ) Slow Heartbeat
( ) High Blood Pressure
( ) Low Blood Pressure
( ) Lung Problems
( ) Swelling of Ankles
( ) Poor Circulation
( ) Hardening of Arteries
( ) Rheumatic Fever
( ) Varicose Veins

RESPIRATORY

( ) Chest Pain
( ) Chronic Cough
( ) Difficulty Breathing
( ) Spitting up Blood
( ) Wheezing

GENITO-URINARY

( ) Frequent Urination
( ) Inability to control kidneys
( ) Painful Urination
( ) Discolored Urine
( ) Kidney infection or stones
( ) Prostate Troubles

MUSCLES & JOINTS

( ) Low Back Pain
( ) Leg Pain
( ) Hip Pain
( ) Knee Pain
( ) Foot Trouble
( ) Neck Pain or Stiffness
( ) Shoulder Pain
( ) Arm Pain
( ) Elbow Pain
( ) Hand Pain
( ) Swollen, Stiff, Painful Joints
( ) Arthritis
( ) Broken Bones
( ) Sore or Weak Muscles
( ) Bursitis

GASTRO-INTESTINAL

( ) Poor Appetite
( ) Excessive Appetite
( ) Difficulty Chewing/ Swallowing
( ) Excessive Thirst
( ) Nausea
( ) Vomiting Food
( ) Vomiting Blood
( ) Abdominal Pain
( ) Diarrhea
( ) Constipation
( ) Black or Bloody Stool
( ) Hemorrhoids
( ) Liver Trouble
( ) Gall Bladder Problem
( ) Weight Problem

EYES, EARS, NOSE & THROAT

( ) Asthma
( ) Ear Discharge
( ) Ear Noises
( ) Ear Ache
( ) Ear Pain
( ) Hearing Loss
( ) Nasal Obstruction
( ) Sinus Infection
( ) Nosebleeds
( ) Sore Gums
( ) Dental Problem

SKIN

( ) Bruise Easily
( ) Dryness
( ) Skin Eruptions (Rash)

WOMEN'S HEALTH

( ) Cramps or Backache
( ) Excessive Menstrual Flow
( ) Hot Flashes
( ) Irregular Cycle
( ) Lumps in Breast
( ) Menopausal Symptoms
( ) Painful Menstruation
( ) Vaginal Discharge
( ) Pregnant

Approximate date of last:

Physical Exam: _____ Blood Test: _____ Urine Test: _____ Chest X-Ray: _____ Spinal X-Ray: _____ Dental X-Ray: _____

Family History: List any serious illnesses and/ or diseases of family members including grandparents:

_____

Mark the condition you have experienced using the letter "M".

Mark the conditions a family member has experienced using the letter "F".

Alcoholism ___ Anemia ____ Appendicitis ____ Cancer ____ Diabetes ____ Eczema ____ Emphysema _____ Foot Problems _____Goiter ____

Gout ____ Heart Disease ____ Ulcers ____ Miscarriage ____ Multiple Sclerosis ____ Rheumatic Fever ____ Stroke ____ Tuberculosis ____

* Clinical summaries will automatically be waived. *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)* If you would like to automate your summary via a web portal, check here. ☐

Signature of PATIENT, PARENT OR GUARDIAN: _____ Date: _____