Weinzoff Chiropractic & Wellness Center

OFFICE USE ONLY
Case: ____________
Date: ____________
Time: ____________

PERSONAL HISTORY

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as **neat and accurate** as possible when completing this form.

IMPORTANT: If your condition is due to a work-related injury or the result of an automobile accident or similar liability accident, PLEASE STOP—DO NOT COMPLETE THIS FORM. See our front office staff for further instructions.

Patient Information

Name: ______________________________ **Date of Birth:** ______________
(First, Middle, Last Name) *(Date of Birth)*

Address: ______________________________ ______________________
(Street Address) *(City, State, Zip Code)*

Contact Info: ______________ ______________ ______________
(Home Telephone Number) *(Work Telephone Number)* *(e-mail Address)*

Social Security Number: ______________ **Driver's License Number:** ______________

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed
Sex: ❑Male ❑Female
Employment Status: ❑Employed ❑ Part-time Student ❑ Full-time Student ❑ Other

Employment Information

______________ ______________
(Occupation) *(Employer)*

______________ ______________
(Address) *(City, State, Zip)*

Insurance Information

______________ ______________ ______________
(Name of Insured) *(Date of Birth)* *(Relationship to Patient)*

______________ ______________ ______________
(Insurance Company) *(Group Number)* *(ID Number)*

______________ ______________
(Address) *(City, State, Zip Code)*

How were you referred to our office?

❑ By an Attorney
❑ By a Doctor
❑ By a Patient
❑ Other

Please print the name of your source below.

____

Current Complaint(s)

Please describe the principal health problem(s) for which you came to this office:

____

____

____

HEALTH QUESTIONAIRE:
For each of the questions below, please indicate whether or not your have experience persistent symptoms.
Codes: 1 for NEVER had; 2 for PREVIOUSLY had; 3 for CURRENTLY have.

MUSCULO-SKELETAL
___Low back problems
___Pain b'twn shoulders
___Back problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Neck pain
___Walking problems
___Mid-back pain
___Broken bones
___Wrist pain
___ Headaches

URINARY SYSTEM
___Bladder trouble
___Excessive urination
___Scant urination
___Painful urination
___Discolored urine

FEMALE SYSTEM
___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast

GASTRO-INTESTINAL
___Poor appetite
___Excessive hunger
___Difficulty chewing
___Difficulty swallowing
___Excessive thirst
___Nausea
___Vomiting food
___Vomiting blood
___Abdominal pain
___Diarrhea
___Constipation
___Black stool
___Bloody stool
___Hemorrhoids
___Liver trouble
___Gall bladder probs.
___Weight trouble

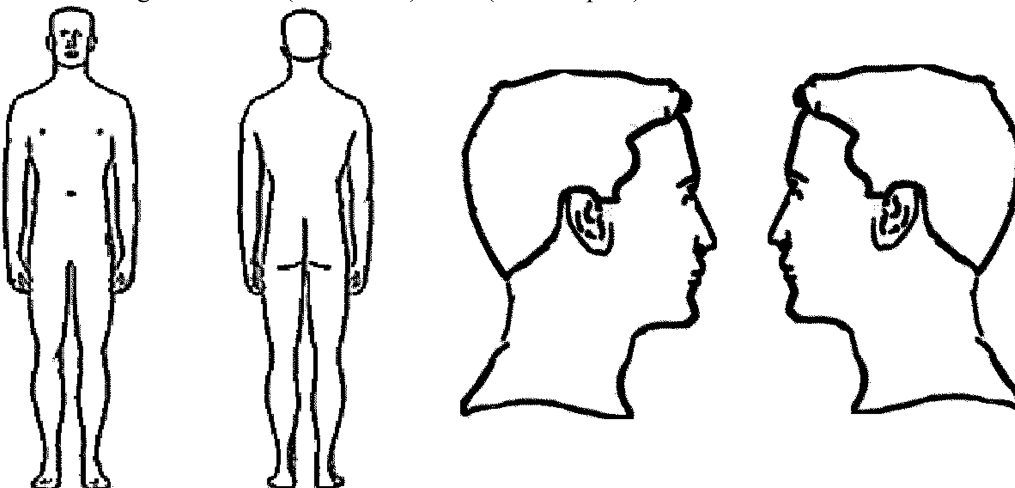
NERVOUS SYSTEM
___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression

CARDIO RESPIRATORY
___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid heartbeat
___Blood pressure prob.
___Heart problems
___Lung problems
___Varicose veins

EYE, NOSE & THROAT
___Eye strain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Hearing loss
___Ear discharge
___Nose pain
___Nasal bleeding
___Nasal discharge
___Difficult breathe by nose
___Sore gums
___Dental problems
___Sore mouth
___Hoarseness
___Difficulty speaking

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury of discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



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Have you consulted any other doctor(s) in regard to your current condition? Yes ____ No ____

If "Yes," please list other doctor(s) consulted. ____

If "Yes," please list all relevant diagnoses. ____

If "Yes," please list any relevant treatment. ____

Have you suffered from any similar conditions or injuries in the past? Yes ____ No ____

If "Yes," please explain. ____

Have you ever received chiropractic treatment previously? Yes ____ No ____

If "Yes," please tell us when and for what symptom(s). ____

____

In the past year, have you been treated by a physician for any health condition? Yes ____ No ____

If "Yes," please explain. ____

Please list the approximate dates of any surgical procedures or significant diseases you may have had.

____

Consent to Treatment

I hereby request and consent to the performance of chiropractic examination and treatment.

Financial Responsibility and Assignment of Benefits

By signing below I hereby agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read all three pages of this form and understand its contents.

____ ____________________________

(Patient or Other Legally Authorized Person) ***(Date)***

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