



Wexford Chiropractic Centre

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Full Name _____ Date _____

Mailing address _____

Home Phone () _____ Street _____ City _____ State _____ Zip _____
Work Phone () _____

Cell Phone () _____ Social Security # _____

Spouse/Guardian Name _____ Occupation _____

Marital Status: M S W D Age _____ Birth date _____ No. of children _____

Pregnant? _____ Height _____ Weight _____ Occupation _____

Do you have Health Insurance? Yes _____ No _____

If "Yes", what is the name of the company? _____

Do you have Medicare Coverage? Yes _____ No _____

WHO MAY WE THANK FOR REFERRING YOU? _____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" section

I. HEALTH CONCERNS

List health concerns According to their severity Present	Rate of severity 1 mild 10 worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit? _____

I do (do not) have a family history of this or similar symptoms (Please explain) _____

What activities aggravate your condition? _____

Other Doctor's seen for this condition:

Chiropractic Dr. _____ Medical Dr. _____ Other _____

1. Name/Address: _____

When: _____ What did they say was wrong? _____

What did they do? _____ Did it help? _____

2. Name/Address: _____

When: _____ What did they say was wrong? _____

What did they do? _____ Did it help? _____

Is this condition interfering with your: work _____ sleep _____ daily routine _____ sports/exercise _____

GENERAL HEALTH HISTORY SECTION

Have you had any surgery? (Please include all surgery)

1. Type _____ When _____ Doctor _____
 2. Type _____ When _____ Doctor _____
 3. Type _____ When _____ Doctor _____
 4. Type _____ When _____ Doctor _____

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type _____ When _____ Hospitalized _____ Yes _____ No _____
 2. Type _____ When _____ Hospitalized _____ Yes _____ No _____
 3. Type _____ When _____ Hospitalized _____ Yes _____ No _____

Have you ever had x-rays taken? _____ When? _____ Where? _____

Area of body: _____

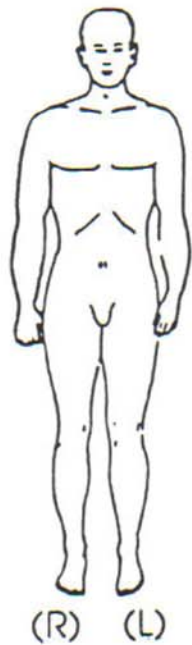
Do you wear orthotics or heel lifts? Yes _____ No _____

CURRENT MEDICINE(S)/SUPPLIMENTS:

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

PLEASE MARK YOUR AREAS OF PAIN BELOW



PAST HEALTH HISTORY

Mark the following conditions you may have had or have now
 (- have had + have now)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Itching |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> HIV (Aids) |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Chronic Colds | |
| <input type="checkbox"/> Pleurisy | | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Nose Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Foot Pain |
| <input type="checkbox"/> Other (Please Explain) | | |

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Soda	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Artif. Sweetnr.	_____	_____	_____	_____
Fried Foods	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

TINGLING OR NUMBNESS IN:

- Shoulder Hips
 Arms Legs
 Elbows Knees

How do you grade your physical health? Excellent ___ Good ___ Fair ___ Poor ___ Getting better ___ Getting worse ___

How do you grade your emotional/mental health? Excellent ___ Good ___ Fair ___ Poor ___ Getting better ___ Getting worse ___

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?

YES _____ NO _____ MAYBE _____

If dietary changes are indicated would you be willing to make changes in your diet?

YES _____ NO _____ MAYBE _____

Would you take whole food supplements if indicated?

YES _____ NO _____ MAYBE _____

Is there anything else which may help to better understand you which has not been discussed?

PRIMARY CARE PHYSICIAN NAME _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will 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. Payment is expected at time of visit.

Name of person responsible for payment _____

Patients Signature _____ Date: _____

Guardian or Spouses Signature _____