Comprehensive Health and Chiropractic Centre
Family Practice - Dr. K

555 South Rancho Santa Fe Road, Ste. 200
San Marcos, CA 92069
(760) 736-0286 · **(**760) 736-3113

PERSONAL DATA

Date:_____ Chart Number:_____

Home phone:_____ Cell phone: _____

Last Name:_____ First Name:_____ M.I.___

Address: _____

City: _____ State:_____ Zip:_____ Work phone: _____

Birthdate:_____ Age:_____ Sex: M F Height:_____ Weight: _____

Please check one: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

SSN:_____/_____/_____ Your Driver's Lic.#:_____

Are you/have you been disabled from work?_____

E-mail address: _____

We call you before your appointment to remind you of the appointment. Would you like to be **reminded** by:

1) Telephone 2) Email 3) Text (Cell Carrier: _____) 4) None (please **circle** your choice)

If telephone number is included, which number? 1) Home 2) Cell 3) Work (please **circle** your choice)

We send text messages (i.e., Happy Birthday): Please provide Cell Carrier: _____

Would you like to receive our newsletter by email? 1) Yes; 2) No (please **circle** your choice)

BUSINESS DATA

Business phone:_____

Business/Employer:_____

Type of work:_____

Address:_____

City: _____ State:_____ Zip:_____

FAMILY DATA

Spouse's name:_____

Social Security #:_____

Business phone #:_____

Business/Employer:_____

Type of work:_____

CHILDREN NAMES

Name _____ Age____

Name _____ Age____

Name _____ Age____

Name _____ Age____

EMERGENCY CONTACT

Name and address of nearest relative not living with you:

Name:_____ Relationship: _____

Phone # (Cell) _____Phone # (Home) _____Phone # (Work) _____

REFERRAL

Referred to this office by:_____

Comprehensive Health and Chiropractic Centre

Dr. Kimberly Rollheiser

INSURANCE

RESPONSIBLE PARTY

Name of person responsible for this account? _____

Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work phone# _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date employed _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone# ( )_____-_____

Insurance Address _____ City _____ State ___ Zip _____

Group# _____ ID# _____

How much is your deductible? _____ How much have you met? _____

Maximum annual benefit? _____

Do you have additional Insurance? NO_____ YES_____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone# ( )_____-_____

Insurance Address _____ City _____ State ___ Zip _____

Group# _____ Employer# _____

How much is your deductible? _____ How much have you met? _____

Maximum annual benefit? _____

PATIENT AGREEMENT

As a courtesy to our patients, Comprehensive Health and Chiropractic Centre is set up to utilize direct payment from insurance companies. However, it is important to understand that your health and accident insurance policy is an arrangement between you and your insurance company. You are personally responsible for all service charges incurred in our office. Until your insurance coverage has been verified, we expect payment in full when the services are rendered.

We ask that you keep our deductible charges current. After your deductible has been met, we request that you continue to keep your portion of your claim up to date. You are required to sign an "authorization and assignment of benefits" from and any other documents required by your insurance company on your first office visit. You are responsible for providing this office with insurance information and claim forms. You will be considered a cash-paying patient until this information is received. Our office does not guarantee that your insurance will pay. Regardless of what type of insurance you have, you are ultimately responsible for your account. Most insurance companies do not cover the cost of vitamin supplements and orthopedic supplies. Therefore, these costs are the responsibility of the patient. Payment must be made upon receipt of supplies.

_____ _____/_____/_____

Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and hereby release you of any consequence thereof.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collection counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at anytime, I agree to notify the office immediately.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Staff Signature Date

Greetings,
Dr. Kimberly Rollheiser is a detail-oriented doctor. It is in your best interest to fill out the forms as completely as possible. Doing so will help Dr. Rollheiser do a better job of diagnosing your health concerns and creating an effective healing plan designed especially for you.

The forms are broken down into the following sections:
Section 1: Current Health Concerns (what's bothering you that made you seek relief?)
(please give a brief description in this area; reserve the details for each appropriate section)
Section 2: Musco-Skeletal (joint and muscle pain, tingling in the extremities, stiffness, etc.)
Sections 3 – 10: Problems with the Organ Systems of your body (appendectomy, tonsillectomy, heart attack, etc.)

Section 3 – General	**Section 4** – Nervous System
Section 5 – Genitro-Urinary	**Section 6** – Cardiovascular/Respiratory
Section 7 – Eyes, Ears, Nose and Throat	**Section 8** – Gastro-Intestinal
Section 9 – Female Problems	**Section 10** – Male Problems

Sections 11 & 12 – Your Health and Your Family's Health Histories
Section 13 – Your Past Health History
Sections 14, 15, 16 & 17 – Your Diet/Exercise/Work Activity & Habits
Section 18 – Chiropractic Health Questionnaire

CURRENT HEALTH CONDITION

Primary Unwanted Health Condition _____

_____

_____

_____

_____

_____

_____

2nd Unwanted Health Condition_____

_____

_____

_____

_____

_____

_____

_____

CHCC Name: _____ Date: _____ Signature: _____

CURRENT HEALTH CONDITION (cont.)

3rd Unwanted Health Condition _____

4th Unwanted Health Condition _____

5th Unwanted Health Condition _____

6th Unwanted Health Condition _____

MUSCULO-SKELETAL (neck, back, leg, etc.) *{fill out next four pages as needed}*

#1 PAIN COMPLAINT:

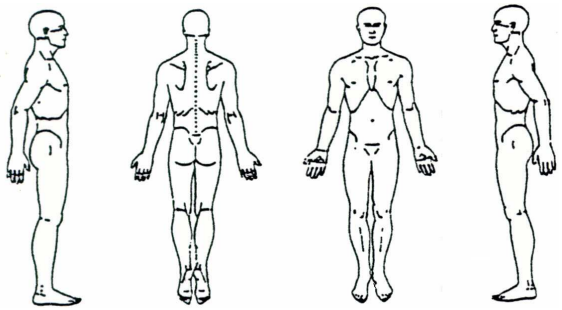
1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT:

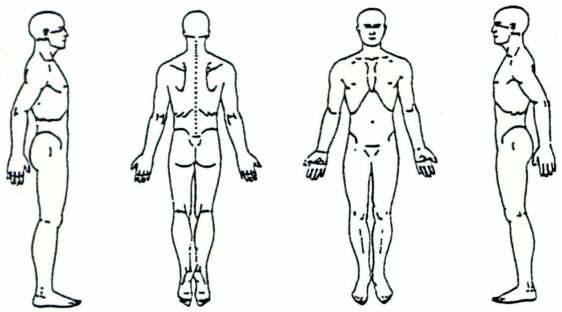
1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

MUSCULO-SKELETAL (neck, back, leg, etc.) *{fill out next four pages as needed}*

#3 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

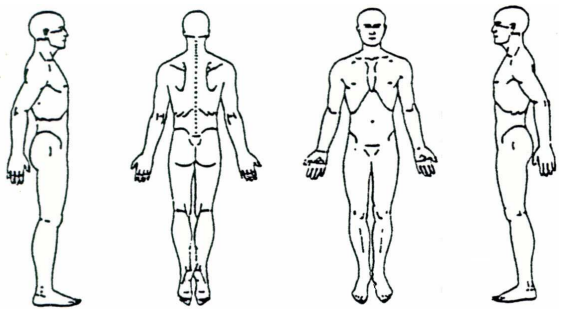
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

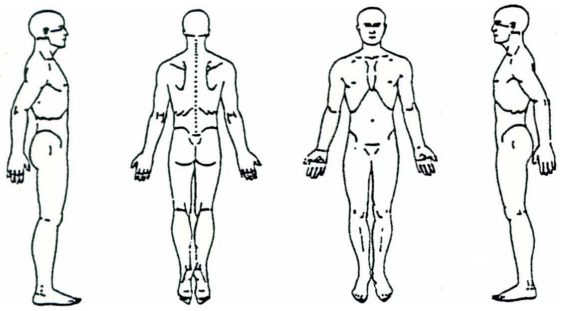
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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1 2 3 4 5 6 7 8 9 10

MUSCULO-SKELETAL (neck, back, leg, etc.) *{fill out next four pages as needed}*

#5 PAIN COMPLAINT:

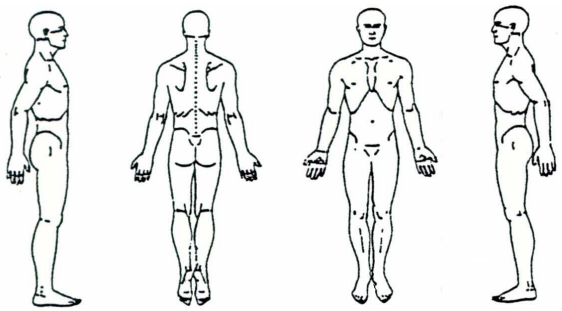
1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#6 PAIN COMPLAINT:

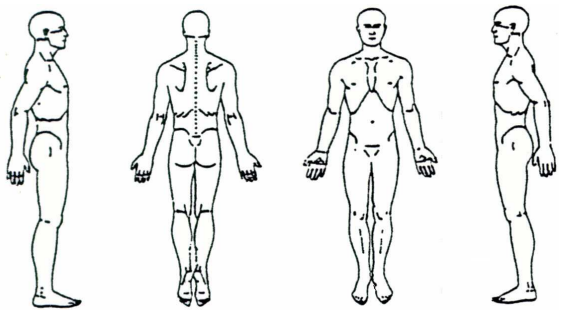
1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

MUSCULO-SKELETAL (neck, back, leg, etc.) *{fill out next four pages as needed}*

#7 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

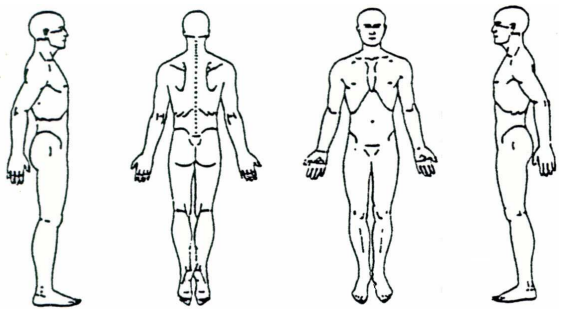
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#8 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

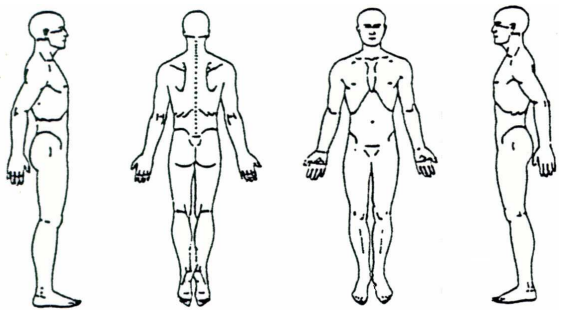
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

GENERAL

What is your primary concern with your ***GENERAL HEALTH***? _____

_____

_____

❑ Fatigue: ❑ Past ❑ Present If present: ❑ Mild ❑ Moderate ❑ Severe Daily? ❑ Yes ❑ No

Is there a pattern? ❑ Yes ❑ No If Yes, describe: _____

❑ Headaches: ❑ Past ❑ Present If Present, how frequent?: ❑ Daily ❑ Weekly ❑ Monthly

Degree: ❑ Mild ❑ Moderate ❑ Severe Location of pain: _____

Is there a pattern? ❑ Yes ❑ No If Yes, describe: _____

How long has this pattern of headaches existed (days/weeks/months/years)? _____

Do you have any idea what causes or triggers your headaches? _____

Females only: Is there a relationship to your menstrual cycle? ❑ Yes ❑ No

❑ Allergies: ❑ Airborne ❑ Food ❑ Unknown

List known allergies: _____

How often? Daily/weekly/monthly, or if seasonally, which seasons? _____

What kind of symptoms do you have with your allergies? _____

❑ Bleeding Tendencies: Where? _____ How often? _____

How severely? _____

How long have you had this problem? _____

❑ Skin Conditions: ❑ Past ❑ Present

Describe condition: _____

List past treatments and effectiveness: _____

❑ Fever:

When was your last fever? _____

How often do you get fevers? _____

How severe do they get? _____

❑ Hydrocortisone Topical Uses:

Name(s) of product(s) you are using: _____

What is the reason you are using the product(s)? _____

How often do you use/apply the product(s)? _____

How long have you been using the product(s)? _____

SLEEP (Sleep patterns, loss of sleep, etc.)

Bedtime_____
Falls asleep easily

☐Yes

☐No

Do you have to do some type of activity to go to sleep? ___ Y ___N
If so, describe the activity:

_____
_____

Do you take anything (supplements or medications) to help you go to sleep or to be able to sleep?

_____
_____
_____
_____
v_____

Do you sleep through the night? ___ Y ___N
If no, what is/are the reason(s)?
____ Urinate
____ Worry/Stress
_____
_____

Falling Back to Sleep

1. ___ Do you go back to sleep **easily**?

2. ___ Do you toss and turn or does your mind remain active?

   How long do you remain awake before falling back to sleep? _____

3. ___ Are you awake, can't go back to sleep and remain awake for the rest of the night until daybreak?

Wake Up

___Are your energies high enough to carry on your normal day?

Rested
Tired
Exhausted

___Are you ready to go back to sleep at 6 a.m.?

___At what time of the day do you get a "lull"?

___At what time of the day do you get a "second wind"?

YOUR DAY

Meal	Time you eat	What food do you eat?	Energy after eating
Breakfast	_____	_____	_____
Snack	_____	_____	_____
Lunch	_____	_____	_____
Snack	_____	_____	_____
Dinner:	_____	_____	_____
Snack	_____	_____	_____

5 NERVOUS SYSTEM

What is your primary concern with your ***NERVOUS SYSTEM***? _____

_____

_____

❑ Nervousness
Do you consider yourself to be a "nervous type" in general? _____
Are you feeling nervous about something specific? _____

❑ Forgetfulness
Are you forgetting recent events? _____
Events from the distant past? _____
Do you forget other things? _____
Is memory worse with stress? _____

❑ Numbness
Where? _____
When did it start? _____
Frequency: ❑ Occassional ❑ Intermittent ❑ Frequent ❑ Constant

❑ Dizziness: ❑ Past ❑ Present

❑ Fainting: ❑ Past ❑ Present

❑ Stress: ❑ Past ❑ Present
If present, what areas of your life do you consider to be stressful? _____

❑ Depression: ❑ Past ❑ Present
If present, how long have you been depressed? _____
Have you ever taken prescribed medications for depression? ❑ Yes ❑ No
If yes, list medications: _____
Are you getting professional counseling? ❑ Yes ❑ No Is there a family history of depression? ❑ Yes ❑ No
Is your current depression related to a specific situation? ❑ Yes ❑ No
Is your depression: ❑ Mild ❑ Moderate ❑ Severe

❑ Cold or Tingling Extremities ❑ Hands ❑ Feet ❑ Both Date of onset: _____
Frequency: ❑ Occasionally ❑ Intermittent ❑ Frequent ❑ Constant

6 GENITRO URINARY

What is your primary concern with your ***GENITRO-URINARY***? _____

_____

_____

❑ Bladder Infections:
When was your last one? _____ How often do you have one? _____
What factors do you think cause or influence this condition? _____

❑ Frequent Urination: (other than associated with bladder infections) How frequent? (times per day) _____

❑ Discolored Urine: ❑ Past ❑ Present If present, when did it begin? _____

❑ Incontinence: ❑ Past ❑ Present If present, when did it begin? _____

❑ Dribbling: ❑ Past ❑ Present If present, when did it begin? _____

❑ Blood in Urine : ❑ Past ❑ Present If present, when did it begin? _____

CARDIOVASCULAR/RESPIRATORY

What is your primary concern with your ***CARDIOVASCULAR/RESPIRATORY SYSTEM***? _____

_____

_____

_____

❑ Chest Pain: ❑ Past ❑ Present If present, when does it occur? _____

Treatment? _____

❑ Shortness of Breath: ❑ Past ❑ Present

When does it occur? _____

❑ Heart Disease: ❑ Past ❑ Present

Describe: _____

❑ Ankle Swelling: ❑ Past ❑ Present

If present, is it constant? _____

❑ Blood Pressure Problems: ❑ Past ❑ Present ❑ High ❑ Low

Medication: _____

❑ Lung Problems/Congestion:

Describe: _____

❑ Stroke: When? _____

Residual problems? _____

❑ Chronic Cough: _____When did it start? _____ Are you a smoker? _____

❑ Irregular Heartbeat/Murmurs (circle one or both):

Describe: _____

Have you seen a medical doctor for this? _____

❑ Varicose Veins: ❑ Past ❑ Present When did they start? _____ Are they painful? _____

What aggravates them? _____

EYES, EARS, NOSE AND THROAT

What is your primary concern with your ***EYE, EARS NOSE AND/OR THROAT***? _____

_____

_____

_____

❑ Vision Problems: ❑ Past ❑ Present Specify problem: _____When did it begin? _____

List treatments: _____

❑ Earaches/Infections: ❑ Past ❑ Present When was the last episode? _____

How often do they occur? _____ Severity of the problem? _____

List treatment: _____

❑ Dental History:

List present problems: _____

List past problems: _____

Have you ever had braces/orthodontics? ❑ Yes ❑ No Were teeth extracted as part of your treatment? ❑ Yes ❑ No

If yes, how many? _____ Who is your present dentist? _____

❑ Hearing Difficulty: ❑ Past ❑ Present

Please describe: _____

When did it begin? _____ List any treatment and its effectiveness: _____

_____

❑ Sore Throat: ❑ Past ❑ Present If present, when did it begin? _____ How severe is it? _____

What do you think caused or influenced this condition? _____

List any treatment and its effectiveness: _____

❑ Nose and Sinus Problems: ❑ Past ❑ Present

Describe: _____

When did it begin? _____ How severe is it? _____

What do you think causes or influences this condition? _____

List any treatment and its effectiveness: _____

❑ Noises in Ear: ❑ Past ❑ Present

Describe: _____

When did it begin? _____

What do you think causes or influences this condition? _____

GASTRO-INTESTINAL

What is your primary concern with your ***GASTRO-INTESTINAL SYSTEM***? _____

_____

_____

_____

❑ Poor/Excessive Appetite (circle one or both): ❑ Past ❑ Present When did it start? _____

❑ Weight change: As an adult, what has your weight range been? High: _____ Low: _____

Do you feel you have an unhealthy relationship with food? ❑ Yes ❑ No Are you a compulsive eater? ❑ Yes ❑ No

Are you or have you ever been considered: ❑ Anorexic ❑ Bulimic

Do you feel over-concerned or obsessed with your weight and/or body image? ❑ Yes ❑ No

❑ Heartburn: Frequency: ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

All foods? _____ Certain foods only? _____

Is there a time of day when it is worse? _____

❑ Excessive Thirst: ❑ Past ❑ Present When did it begin? _____

❑ Ulcers: When did it start? _____ Treatment? _____

❑ Nausea: ❑ Past ❑ Present If present, frequency: ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

❑ Vomiting: ❑ Past ❑ Present If present, when did it start? _____

❑ Gas/Bloating After Meals: ❑ Past ❑ Present If present, all meals? ❑ Yes ❑ No

Certain foods? _____

❑ Abdominal Cramps/Pain: ❑ Past ❑ Present If present, location: _____

When did they occur? _____ Intensity: ❑ Mild ❑ Moderate ❑ Severe

❑ Colitis: ❑ Past ❑ Present If present, when did it start? _____

What factors effect it? _____

❑ Bowel Movements: Times per day _____ Times per week _____

❑ Diarrhea: ❑ Past ❑ Present If present, frequency: ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

When did it start? _____

What do you think causes or influences it? _____

Is it related to: ❑ Specific foods ❑ Stress

❑ Constipation: ❑ Past ❑ Present If present, when did it begin? _____

Is this a lifetime pattern? ❑ Yes ❑ No

What do you think causes or influences this condition? _____

Do you take any medications or natural substances to assist in bowel function (list) _____

_____

❑ Black/Bloody Stool: ❑ Past ❑ Present When did it start? _____

❑ Hemorrhoids: ❑ Past ❑ Present Are they: ❑ Painful ❑ Bleeding

What factors affect it? _____

❑ Gall Bladder Problems: ❑ Past ❑ Present If present, describe symptoms: _____

❑ Liver Problems: ❑ Past ❑ Present If present, describe symptoms: _____

Time of day _____ Certain foods? _____ Other factors? _____

❑ Hepatitis: ❑ Past ❑ Present When did it start? _____

FEMALE PROBLEMS

What is your primary concern with your ***FEMALE PROBLEMS***? _____

_____

_____

_____

Your age at first period: _____ Most recent period began date: _____

How many days do you flow? _____ How many days from period to period? _____

Last PAP smear: _____ History of abnormal PAP? ❑ Yes ❑ No

If Abnormal, what class? _____

Treatment? _____

❑ Pregnancies: No._____ Live births _____ Are you pregnant now? ❑ Yes ❑ No ❑ Unsure

❑ Nursing: Breastfeeding: ❑ Yes ❑ No

❑ Infertility: ❑ Past ❑ Present

❑ Contraception: Past history of birth control pill use: How long? _____ Side effects? _____

Past types: ❑ IUD ❑ Foam ❑ Condoms ❑ Other_____

Present types: _____

❑ Menstrual Cramping: ❑ Mild ❑ Moderate ❑ Severe

Do you get cramps every month? ❑ Yes ❑ No

If not, how often? _____

❑ Spotting

❑ PMS (Pre-menstrual Syndrome): ❑ Yes ❑ No If yes: ❑ Mild ❑ Moderate ❑ Severe

How many days of symptoms before your period? _____

Check symptoms:

❑ Breast tenderness: ❑ Food cravings: ❑ Irritability

❑ Crying easily ❑ Bloating/weight gain ❑ Suicidal:

❑ Other: _____

❑ Painful Intercourse: ❑ Past ❑ Present

❑ Breast Lumps/Fibrocystic: ❑ Past ❑ Present

❑ Vaginal Infections/Yeast: ❑ Past ❑ Present Frequency, how many times per year? _____

❑ DES Mother

❑ Sexual Dysfunction: ❑ Past ❑ Present Describe: _____

❑ Ovarian, Vaginal or Uterine Problems: ❑ Past ❑ Present

Treatment: _____

MALE PROBLEMS

What is your primary concern with your ***MALE PROBLEMS***? _____

_____

_____

_____

❑ Prostate Problems: ❑ Past ❑ Present

If present, describe symptoms: _____ When did this begin? _____

List any treatment and its effectiveness: _____

❑ Incomplete Voiding of Urine: ❑ Past ❑ Present

If present, describe symptoms: _____

When did this begin? _____

List any treatment and its effectiveness: _____

❑ Pain during Urination: ❑ Past ❑ Present

If present, describe symptoms: _____ When did this begin? _____

List any treatment and its effectiveness: _____

❑ Sexual Dysfunction: ❑ Past ❑ Present

If present, describe symptoms: _____ When did this begin? _____

List any treatment and its effectiveness: _____

THYROID

❑ Are you taking thyroid medication? ___Yes ___No ❑ Diagnosis Date: _____

❑ Name(s) of Medication(s): _____

How long have you been on the medication(s)? _____

❑ Do you have a goiter? ___Yes ___No If yes, what date were you diagnosed? _____

❑ Do you have an autoimmune thyroid? ___Yes ___No If yes, what date were you diagnosed? _____

Describe the symptoms that you **originally** had: _____

_____

Describe the symptoms you **currently** are experiencing: _____

_____

HEALTH HISTORY – ***Please check the box(es) on the LEFT SIDE of the table that pertains to YOU; check the box(es) on the RIGHT SIDE of the page that pertains to your FAMILY MEMBERS (mother, father, sister, brother, cousin, aunt uncle, grandmother, etc.). If you have additional treatments, please write them on the back with the corresponding number (ex., put on back 8. Asthma – Proventil and Respirtone).***

	YOUR HEALTH HISTORY				FAMILY HEALTH HISTORY		
	Ailments	Surgery Date	Age	Treatment	Relation	Deceased (Yes/No)	Age of Death
1	❑AIDS/HIV					Yes / No	
2	❑Alcoholism					Yes / No	
3	❑Allergy Shots					Yes / No	
4	❑Anemia					Yes / No	
5	❑Anorexia					Yes / No	
6	❑Appendicitis					Yes / No	
7	❑Arthritis					Yes / No	
8	❑Asthma					Yes / No	
9	❑Bleeding Disorders					Yes / No	
10	❑Breast Lump					Yes / No	
11	❑Bronchitis					Yes / No	
12	❑Bulimia					Yes / No	
13	❑Cancer					Yes / No	
14	❑Cataracts					Yes / No	
15	❑Chemical Dependency					Yes / No	
16	❑Chicken Pox					Yes / No	
17	❑Cyst					Yes / No	
18	❑Depression					Yes / No	
19	❑Diabetes					Yes / No	
20	❑Eczema					Yes / No	
21	❑Emphysema					Yes / No	
22	❑Epilepsy					Yes / No	
23	❑Gallstones					Yes / No	
24	❑Genital Warts					Yes / No	
25	❑German Measles/Rubella					Yes / No	
26	❑Glaucoma					Yes / No	
27	❑Goiter					Yes / No	
28	❑Gonorrhea					Yes / No	
29	❑Gout					Yes / No	
30	❑Heart Disease					Yes / No	
31	❑Hemorrhoid					Yes / No	
32	❑Hepatitis A					Yes / No	
33	❑Hepatitis B					Yes / No	
34	❑Hepatitis C					Yes / No	
35	❑Hernia					Yes / No	
36	❑Herniated Disc					Yes / No	
37	❑Herpes					Yes / No	
38	❑High Blood Pressure					Yes / No	
39	❑High Cholesterol					Yes / No	
40	❑Hysterectomy					Yes / No	
41	❑Kidney Disease					Yes / No	
42	❑Liver Disease					Yes / No	
43	❑Lung Problems					Yes / No	
44	❑Lupus					Yes / No	
45	❑Measles					Yes / No	

YOUR HEALTH HISTORY (cont.)					FAMILY HEALTH HISTORY (cont.)		
	Ailments	Surgery Date	Age	Treatment	Relation	Deceased (Yes/No)	Age of Death
46	❑Mental Disorder					Yes / No	
47	❑Migraine Headaches					Yes / No	
48	❑Miscarriage					Yes / No	
49	❑Mononucleosis					Yes / No	
50	❑Multiple Sclerosis					Yes / No	
51	❑Mumps					Yes / No	
52	❑Osteoporosis					Yes / No	
53	❑Other					Yes / No	
54	❑Pacemaker					Yes / No	
55	❑Parkinson's Disease					Yes / No	
56	❑Pinched Nerve					Yes / No	
57	❑Pleurisy					Yes / No	
58	❑Pneumonia					Yes / No	
59	❑Polio					Yes / No	
60	❑Prostate Problems					Yes / No	
61	❑Prosthesis					Yes / No	
62	❑Psychiatric Care					Yes / No	
63	❑Rheumatic Fever					Yes / No	
64	❑Rheumatoid Arthritis					Yes / No	
65	❑Scarlet Fever					Yes / No	
66	❑Small Pox					Yes / No	
67	❑Spinal					Yes / No	
68	❑Stroke					Yes / No	
69	❑Suicide Attempt					Yes / No	
70	❑Thyroid Problems					Yes / No	
71	❑Tonsillitis					Yes / No	
72	❑Tuberculosis					Yes / No	
73	❑Tumors, Growths					Yes / No	
74	❑Typhoid Fever					Yes / No	
75	❑Ulcers					Yes / No	
76	❑Vaginal Infections					Yes / No	
77	❑Venereal Disease					Yes / No	
78	❑Whooping Cough					Yes / No	
						Yes / No	
	Other					Yes / No	
	❑_____					Yes / No	
	❑_____					Yes / No	
	❑_____					Yes / No	
	❑_____					Yes / No	
	❑_____					Yes / No	

PAST HEALTH HISTORY

A. ❑ Have you ever had chiropractic care for other problems? ❑ Yes ❑ No If yes, when? _____

❑ Do you take: ❑ Muscle Relaxers ❑ Pain killers ❑ Over-the-counter medications

B. ❑ Do you have a permanent disability rating? ❑ Yes ❑ No If yes, location: _____

Date received the rating: _____ Rating percentage: _____

C. ❑ List fractures, dislocations, concussions, falls (head injuries, car accidents, fender benders, gym injuries, horses, etc.)

Date	**Description**	**Treatment**

D. ❑ List scar information, including where the scar is on the body and when and how the scar occurred

16 DIET – *please describe your diet by indicating how many times per day/week/month you have the following:*

Eggs	_____	times per	_____	Tea (caffeinated)	_____	times per	_____
Milk products	_____	times per	_____	Alcohol	_____	times per	_____
Wheat products:				Chocolate	_____	times per	_____
Pasta	_____	times per	_____	Other sweets	_____	times per	_____
Bread	_____	times per	_____	Soft drinks	_____	times per	_____
Rolls/muffins	_____	times per	_____	White flour products	_____	times per	_____
Red meat	_____	times per	_____	Water	_____	times per	_____
Chicken	_____	times per	_____	Fried food	_____	times per	_____
Fish	_____	times per	_____	Cigarettes	_____	times per	_____
Fresh vegetables	_____	times per	_____	Grains	_____	times per	_____
Fresh fruit	_____	times per	_____	Foods carved:			
Salad	_____	times per	_____	Meals per day:			
Coffee	_____	times per	_____				

17 MISCELLANEOUS

18 EXERCISE	18 WORK ACTIVITY	19 HABITS	
❑ None	❑ Sitting	❑ Smoking	Packs/Day _____
❑ Moderate	❑ Standing	❑ Alcohol	Drinks/Week_____
❑ Daily	❑ Light Labor	❑ Drug (Recreational)	Times/Week _____
❑ Heavy	❑ Heavy Labor	❑ Coffee/Caffeine Drinks	Cups/Day _____
	❑ Computer Work	❑ High Stress Level	Reason _____

20 CHIROPRACTIC HEALTH QUESTIONNAIRE

❑ Other prescription drugs: _____

Sleep _____ hrs/night Do you sleep on your: ❑ Back ❑ Side ❑ Stomach

Age of mattress _____ or waterbed _____ Is your bed comfortable? ❑ No ❑ Yes

What kind of pillow do you use? ❑ Thick ❑ Medium ❑ Thin ❑ None ❑ Support Age of pillow: _____

Do you wear: ❑ Heel lifts ❑ Shoe lifts ❑ Arch supports ❑ Orthotics, describe _____

21 CHCC AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

_____ Patient Signature _____/_____/_____ Date

_____ Parent or Guardian Signature (if patient is minor) _____/_____/_____ Date

_____ Staff Signature _____/_____/_____ Date