

Personal History

Date: _____

Patient Name (Last): _____ (First): _____ (Middle): _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Home Phone: (____) _____

Work Phone: (____) _____ Cell Phone: (____) _____

Do you prefer to be contacted by (please circle one): Phone or Email

Fax: (____) _____ Social Security #: _____ - _____ - _____ Driver's License # _____

DOB: ___ / ___ / ___ Age: _____ Gender: M ___ F ___

Marital Status: S ___ M ___ D ___ W ___ Number of Children _____

Occupation: _____ Work Status: ___ Full time ___ Part-time ___ Retired ___ Unemployed

Employer/ Address: _____

Work Activity: ___ Heavy Labor ___ Light Labor ___ Mostly Sitting ___ Mostly Standing ___ Walking / Moving ___ Driving

Name of Spouse: _____ Occupation: _____

Is this condition due to injury or sickness arising out of an accident (auto or other)? _____

If auto, what is your auto policy number? _____

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

Name: _____ Home Phone (____) _____ Cell Phone: (____) _____

Address: _____

Name of your primary doctor: _____ Phone (____) _____

How did you hear about our clinic? _____

I, the undersigned, understand and agree to authorize Minors' Chiropractic, Inc. (*Rehabfx*) and all employees to administer whatever examination and procedures as they deem necessary. Fees are payable at the time of service unless other arrangements are made in advance. I agree that medical records may be transmitted to me or other health care providers via email, fax, or mail.

X _____

Patient Signature

X _____

Signature of Authorizing Parent/Guardian (if minor)

How would you describe your chief complaint at this time?

When did it start? _____ (Include year, month, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: Intermittent Constant

Have you had this problem in the past? _____ If so, how often? _____

Have you seen another doctor for this condition? Yes No If so, who? _____

Please list any medications, vitamins, or supplements you have taken in the past 30 days and why.

Name

Reason

REVIEW OF SYSTEMS

We want all the facts about your health before we accept your case. Please check the appropriate box for any of the following symptoms which you now have or have had previously and briefly explain.

This is a confidential health report:

N – Never **O** – Occasional **F** – Frequent **C** – Constant

N O F C

GENERAL

- ___ ___ ___ **Allergies** _____
- ___ ___ ___ **Convulsions** _____
- ___ ___ ___ **Dizziness** _____
- ___ ___ ___ **Fainting** _____
- ___ ___ ___ **Fatigue** _____
- ___ ___ ___ **Fever** _____
- ___ ___ ___ **Headache** _____
- ___ ___ ___ **Loss of sleep** _____
- ___ ___ ___ **Loss of weight** _____
- ___ ___ ___ **Nervousness / Depression** _____
- ___ ___ ___ **Neuralgia** _____
- ___ ___ ___ **Numbness** _____
- ___ ___ ___ **Sweats** _____
- ___ ___ ___ **Tremors** _____

OTHER SYSTEMS

- ___ ___ ___ **SKIN** _____
- ___ ___ ___ **RESPIRATORY** _____
- ___ ___ ___ **GASTROINTESTINAL** _____
- ___ ___ ___ **CARDIOVASCULAR** _____
- ___ ___ ___ **MUSCLE & JOINTS** _____
- ___ ___ ___ **EYES, EARS, NOSE, & THROAT** _____
- ___ ___ ___ **GENITOURINARY** _____

FOR WOMEN ONLY

- ___ ___ ___ **Fibrocystic / Congested breasts** _____
- ___ ___ ___ **Cramps or backache** _____
- ___ ___ ___ **Excessive menstrual flow** _____
- ___ ___ ___ **Hot flashes** _____
- ___ ___ ___ **Irregular cycle** _____
- ___ ___ ___ **Menopausal symptoms** _____
- ___ ___ ___ **Painful menstruation** _____
- ___ ___ ___ **Vaginal discharge** _____

Are you pregnant? ___ Yes ___ No If yes, date of LMP: _____

SIGNATURE: _____ DATE: _____