

Personal History

Date: _____

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

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

Email address: _____ Home Phone: (____) _____

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

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)

Please list your chief complaint(s) in order from worst to best. If initially due injury, please describe in detail:

1. _____ Onset _____ AND (circle): **Constant** **Varies** **Absent (how long?)** _____

Rate your pain: Best **0 1 2 3 4 5 6 7 8 9 10** Worst

2. _____ Onset _____ AND (circle): **Constant** **Varies** **Absent (how long?)** _____

Rate your pain: Best **0 1 2 3 4 5 6 7 8 9 10** Worst

3. _____ Onset _____ AND (circle): **Constant** **Varies** **Absent (how long?)** _____

Rate your pain: Best **0 1 2 3 4 5 6 7 8 9 10** Worst

4. _____ Onset _____ AND (circle): **Constant** **Varies** **Absent (how long?)** _____

Rate your pain: Best **0 1 2 3 4 5 6 7 8 9 10** Worst

Have you seen another healthcare provider for these conditions? Yes No

If so, who? (please list names & specialities) _____

Have you had x-rays or MRIs taken of the area(s)? _____ When? _____

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

Name

Reason

HIPAA GUIDELINES FOR REHABFX ARE AVAILABLE FOR REVIEW UPON REQUEST

2404 Lake Austin Blvd, Austin, TX 78703 -- Rehabfx.com -- Tel: 512.480.9999 // Fax: 512.457.0894

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:** _____