Mid Missouri Clinic of Chiropractic

Patient History

Name_____ Date_____

Address_____ City/State_____Zip Code_____

SSN_____ Drivers license number_____

Male or Female Birthday_____ Age_____ Married____ Single____ Other_____

Home Phone_____ Cell Phone_____ Work Phone_____

Occupation _____Employer_____

Employers Address_____ City/State_____ Zip Code_____

Email Address_____

Emergency
Contact_____

How did you hear about Mid- Missouri Clinic of Chiropractic? _____

Insurance Information

Do you have insurance that covers chiropractic treatment? YES NO (If no then skip this section)
Do you have health insurance where you work? YES NO
Insurance company _____ Plan ID_____
Insured same as patient? YES NO (If yes then skip next three lines)
Patient relationship to Insured: Self Spouse Child Other
Insured Name_____ Address_____
Insured DOB___/___/____ Insured Gender M F Insured Phone Number(___)-____-_____

History

Are you here because you were injured while working, in a motor vehicle collision or in another accident? Yes No When_____
List any past diseases or conditions you have been diagnosed with: (diabetes, cancer heart disease ect)
_____
_____
_____

List major surgeries and allergies, illness, traumas, or other hospitalizations you have/had_____
_____

List current or past medications_____

Have you ever been to a chiropractor before? If so why and when?

_____

_____

What is your level of stress? HIGH MED LOW

Explain_____

Presenting Problem

Briefly describe your primary pain or symptoms and location_____

Have you missed work due to your pain? Yes No

What makes your pain better? Rest Medication Heat Ice Other

What If any time of day is pain at its worst? MORNING AFTERNOON NIGHT

Describe the pain(burning,aching,shooting,sharp)_____

When did the problem begin_____

Rate the pain as of right now, 0-10(0 being no pain and 10 being excruciating pain)_____

When pain is at its worst 0-10_____

Does pain affect your daily activities? How?

_____

_____

What kinds of treatment have you had for this problem? _____

Have you had any imaging for this problem (X-ray, MRI, CT ect) _____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. 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. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

PLEASE PRINT

What's your major complaint? _____

_____

List surgical operation and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers
☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others: _____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐
HABITS	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

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

NAME:_____

ADDRESS: _____ PHONE: _____

Date:_____

Child History Form

Please complete this detailed history form and return it to the receptionist. Should you require assistance, please let us know as we will be happy to assist.

Child's name: _____ D.O.B. _____

Address: _____

City/State/Zip: _____ _____ _____

Cell phone: _____ Home phone: _____

Doctor's name: _____ Doctor's phone: _____

Doctor's Address: _____

Name of Previous Doctor of Chiropractic: _____

Date of Last Visit (dd/mm/yyyy): _____

Child's Height: _____ Child's Weight: _____

Name(s) of Parent(s) or Guardian(s): _____

Business Telephone: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: _____ _____

Witness: _____

What are your chief concerns, if any, with your child's health? _____

_____

What is your main reason for contacting us? _____

List any other care your child has undergone with regards to this complaint including medication:

_____

Date of onset (mm/yyyy): _____ Onset was: sudden/gradual/assoc with event

Duration of Problem or Episode: Minutes/Hours/Days/Months/Years

Pattern of Problem: Constant/Intermittent/Occasional/Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body function and daily activities? _____

_____

Prior occurrence or episodes? _____

Other health concerns? _____

History of Birth

Hospital/Birthing Center: __ Home __ Medical __Midwife Duration of Gestation:_____weeks
Was the birth assisted? __Yes __ No
If yes, how? __Forceps __Vacuum Extraction __C-Section__Induced Labor
Were medications given to the mother at birth? __ Yes __ No If yes, what? _____
Duration of birth: _____ Was the delivery normal? __ Yes __ No
If no, what complications were there at birth? _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? __ Yes __ No
If no, explain: _____
Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes, etc.)

_____
The father's side? _____
Do the child's siblings have any health problems? __ Yes __ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke __ Yes __ No 2. Drink alcohol? __ Yes __ No
3. Take supplements/vitamins? __ Yes __ No 4. Take drugs? __ Yes __ No If yes, what? _____
5. Become ill? If so, how? _____ 6. Receive ultrasounds? __ Yes __ No If yes, how many? _____ 7. Receive invasive procedures (i.e. amniocentesis, CVS)? __ Yes __ No

Was your child breast fed? __ Yes __ No If yes, for how long? _____ weeks months years
Did your child receive vaccinations? __ Yes __ No If yes, which ones? _____
Did your child react to them? __ Yes __ No
Has your child had antibiotics? __ Yes __ No If yes, how many courses has the child had so far & why? _____
Any pets at home? __ Yes __ No Any smokers at home? __ Yes __ No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? __ Yes __ No Any problems bonding? __ Yes __ No
Does your child seem normal to you? __ Yes __ No
Does the child have any behavior problems? __ Yes __ No If yes, what? _____
Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? __ Yes __ No
If yes, specify: _____
Did your child go to daycare? __ Yes __ No From what age? _____ years
Average number of hours of TV/Computer per week? _____ hours

Traumatic Stressors

Any evidence of trauma during birth? __ Bruises __ Odd shaped head __ Stuck in birth canal
___ Fast and/or excessively long birth __ Respiratory Depression __ Cord around neck
___ Other _____
Any falls/accidents during pregnancy? __ Yes __ No
Has the child had any major falls since birth? __ Yes __ No If yes, did the child need stitches or cause a fracture? Please describe: _____
Any hospitalizations? __ Yes __ No Please explain: _____
Does your child play sports? __ Yes __ No Number of hours per week? _____Age child began __yrs
Weight of school backpack? _____lbs Approx. hours spent at play per week? _____ hrs