PERSONAL AND FAMILY HEALTH HISTORY

Date: 05/01/2020

Full Name: Beth Kirkland I prefer to be called: Beth

Spouse/Guardian: Jim

Address: 100 Main Street

STREET CITY STATE ZIP

Date of Birth: 2AM Age: 49 ◯ Married ◯ Single ◯ Widower

Names of Children	Age	Chiropractic Care	Reason / Wellness
Lauren	2	◯ Yes ◉ No	none
Billy	5	◯ Yes ◉ No	none
Jimmy	8	◉ Yes ◯ No	pain in lower back
Tommy	11	◉ Yes ◯ No	pain in lower neck

Home Tel: (847) 555-1234 Work Tel: (847) 555-1234 Cell Tel: (847) 555-1234

Last 4 of Soc. Sec. #: 1234 (Will be your pin for Chirotouch check in) *Children use primary parent

E-Mail Address: Sales@EclipseCorp.US

Preferred means of appointment reminders: ◯ Email ◉ Text *If text - cell phone carrier needed: ATT

Height: 5'11" Weight: 178 Most recent blood pressure (if known): 87/112

Occupation: Sales Director Employer: Eclipse Corporation

Employer Tel: (847) 555-1234 ◯ Full-Time ◯ Part-Time Pregnant? ◯ Yes ◉ No

Emergency Contact Name: Neil Cummings Phone: (847) 555-1212

Spouse's Employer Name: Jim Kirkland Phone: (847) 555-1212

Who may we thank for referring you to us: GroupOn

◯ Referral ◯ Insurance Co ◯ Internet ◉ Groupon/Living Social ◯ other:

Have you ever been to a chiropractor before? ◯ Yes ◯ No Dr. Brown (DR'S NAME) 26AM (LAST VISIT?)

Date of last physical exam: 2AM By whom? Dr. Bruce Bell

Family doctor: same-Dr. Bruce Bell

Other physicians consulted in past 12 months: none (NAME) DNA (DIAGNOSIS)

Accidents and/or injuries related to current symptoms:

Yes (ACCIDENT OR INJURY) | 03/21/2015 (DATE) | head hit the dashboard (OTHER IMPORTANT INFO. REGARDING INJURY)

(IF AN AUTO, WORK OR PERSONAL INJURY, PLEASE REQUEST INSURANCE FORMS FROM FRONT DESK)

Primary Complaint: lower back pain

- Rate your discomfort 1-10: 7 (10 is worst) At its best 1-10: 3 At its worst: 9
- Frequency of discomfort 0%-100%: _____ Onset: ◯ Gradual ◯ Sudden
- How long since you first noticed the discomfort? 6 weeks ◯ Getting better ◯ worse ◯ no change
- Aggravated by: sitting Relieved by: Advil
- Discomfort is: ◉ sharp ◯ achey ◯ tingling ◯ numb ◯ other: _____
- Time of day when it is most noticeable: evening
- Have you ever had this discomfort before (if yes, explain): yes, pain after lifting bikes at camp at age 22

Secondary Complaint: neck pain

- Rate your discomfort 1-10: 5 (10 is worst) At its best 1-10: 2 At its worst: 6
- Frequency of discomfort 0%-100%: 50 Onset: ◯ Gradual ◯ Sudden
- How long since you first noticed the discomfort? 6 weeks ◯ Getting better ◯ worse ◯ no change
- Aggravated by: computer work Relieved by: massage
- Discomfort is: ◉ sharp ◯ achey ◯ tingling ◯ numb ◯ other: _____
- Time of day when it is most noticeable: _____
- Have you ever had this discomfort before (if yes, explain): _____

Third Complaint: None

- Rate your discomfort 1-10: _____ (10 is worst) At its best 1-10: _____ At its worst: _____
- Frequency of discomfort 0%-100%: _____ Onset: ◯ Gradual ◯ Sudden
- How long since you first noticed the discomfort? _____ ◯ Getting better ◯ worse ◯ no change
- Aggravated by: _____ Relieved by:
- Discomfort is: ◯ sharp ◯ achey ◯ tingling ◯ numb ◯ other: _____
- Time of day when it is most noticeable: _____
- Have you ever had this discomfort before (if yes, explain): _____

Additional information you would like to share with the doctor:
very active, running aggrevates lower back but I don't want to give it up

Daily Activities: Effects of Current Condition on Performance: (1= No limitations – 10=Unable to Perform)

Carrying Groceries	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	◉ 9	○ 10
Changing Positions	○ 1	◉ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Climbing Stairs	○ 1	○ 2	○ 3	◉ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Computer Strain	○ 1	○ 2	○ 3	○ 4	◉ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Driving	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	◉ 7	○ 8	○ 9	○ 10
Household Chores	○ 1	○ 2	○ 3	◉ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Lifting Children	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	◉ 10
Pet Care	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	◉ 8	○ 9	○ 10
Reading/Concentration	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	◉ 9	○ 10
Self-care: Bathing	○ 1	○ 2	◉ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Self-care: Dressing	○ 1	○ 2	○ 3	○ 4	○ 5	◉ 6	○ 7	○ 8	○ 9	○ 10
Self-care: Shaving	◉ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Sexual Activities	○ 1	○ 2	○ 3	○ 4	○ 5	◉ 6	○ 7	○ 8	○ 9	○ 10
Sitting Still	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	◉ 10
Sleep	○ 1	○ 2	○ 3	◉ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Standing Still	○ 1	○ 2	○ 3	○ 4	◉ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Walking	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Yard work	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	◉ 8	○ 9	○ 10

Pertinent personal and family history: of illness, disease or chronic health conditions?

Mark :(S) For Self (F) for Family

F	Alcoholism	F	Cancer		Gastric Reflux	F	High Cholesterol		Pacemaker
S	Allergies		Constipation	F	Gout		Irregularity		Parkinson's Disease
S	Anemia	S	Degenerative Discs	S	Headaches		Kidney Disease	S	Pinched Nerve
	Appendicitis	F	Depression		Heart Disease		Liver Disease	S	Pneumonia
S	Arthritis		Diabetes		Hepatitis	S	Miscarriage		Prostate Problems
S	Asthma		Emphysema	S	Hernia		Multiple Sclerosis		Stroke
S	Auto Immune		Epilepsy		Herpes		Muscle Spasms	S	Thyroid Problems
S	Backaches	S	Fractures	S	Herniated Disc		Osteoporosis		Tumors
S	Bronchitis		Gallbladder	F	High Blood Pressure		Other: none		

Do you expect health insurance to contribute to your care? ◉ Yes ○ No

Health Insurance Carrier: Aetna

List all Surgeries:

repaired hernia

List all Medications/Vitamins:

synthroid, Advair, ProAir

HEALTH SURVEY

Alcohol:	◯ Daily	◯ Weekly	◯ Occasional	◯ Never
Smoking:	◯ Daily	◯ Weekly	◯ Occasional	◯ Never
Caffeine:	◯ Daily	◯ Weekly	◯ Occasional	◯ Never
Exercise:	◉ Daily	◯ Weekly	◯ Occasional	◯ Never
Pain Meds:	◉ Daily	◯ Weekly	◯ Occasional	◯ Never
Diet:	◉ Good	◯ Fair	◯ Poor	
Sleep:	◉ Back	◯ Side	◯ Stomach	
Mattress:	◉ Firm	◯ Soft	◯ other: _____	
Allergies:	◉ Food	◯ Seasonal	◯ Meds	◯ Latex ◯ other: _____
Breast Implants?	◯ Yes	◯ No		

Do you expect health insurance to contribute to your care? ◯ Yes ◯ No

Health Insurance Carrier: Yes

Our goal at Van Ness Chiropractic is to provide complete care for you, your spouse and your children. Please make us aware of any injuries, birth trauma, growth and developmental concerns or recurrent childhood conditions regarding your spouse or children.

none

Given your current understanding of chiropractic what are your goals for care?

◉ Just pain relief
◯ Pain relief, plus improved spinal posture
◯ Pain relief, improved spinal posture, plus long term increased vitality and spinal wellness

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE EVENT COLLECTION EFFORTS BECOME NECESSARY, I AGREE TO PAY ALL COLLECTION COSTS, UP TO 40% REASONABLE ATTORNEY FEES, AND COURT COSTS. I ALSO AGREE TO PAY INTEREST AFTER 30 DAYS AT 5% MONTHLY ON ANY UNPAID AMOUNTS.

SIGNATURE OF PATIENT OR GUARDIAN _____

In special circumstances, other arrangements will be made to accommodate your health care needs regardless of your ability to pay. Simply talk to the doctor.