CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY

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Patient Name: (First, MI, Last, Sr., Jr., etc.)		Today's Date:	Soc Sec:	
Address:		City:	State:	Zip Code:
Home Telephone:	Cell Telephone:	Children: ☐ Y ☐ N	Status: ☐ Single ☐ Married ☐ Widow ☐ Life Partner	
Insurance Provider:	Driver's License #:	Gender: ☐ M ☐ F	Significant Other's Name:	
Occupation:	Date of Birth: (mm-dd-yyyy)	Age:	Email Address:	
Emergency Contact Name:			Emergency Contact Telephone:	

Who is Responsible for Your Bill, You and ☐Personal Insurance ☐Spouse ☐Medicare ☐Medicaid ☐ NONE ☐Worker's Comp- Claim #: _____ ☐Auto Insurance **SEE AUTO ACCIDENT INTAKE FORM	
Personal Health Insurance Carrier:	Health Card ID #:
Insured Person's Name:	Group #:
Insured Person's Date of Birth:	Insured Person's Social Security #:

Have You Had Previous Chiropractic Care? ☐ Y ☐ N	Have You Had Previous Therapy Care? ☐Occupational Therapy ☐Physical Therapy ☐Speech Language
Name of Previous Chiropractor:	If you have had therapy, were you treated within the last year? ☐ Y If Yes, When (mm-yyyy)? _____ ☐ N
Amount of Time Under Care of Chiropractor:	If Yes, Name of Clinic and Therapist:

CURRENT HEALTH CONDITION

1. Chief Complaint (why you are here today): _____
_____
_____
2. When did this condition begin? _____
3. Has it ever occurred before? ☐ Y ☐ N
4. MECHANISM OF ONSET: Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (Example: fall, auto injury, sports trauma, repetitive motion on the job, etc.)
_____
_____
5. SYMPTOMS: When this problem is at its worst, can you explain in your words how exactly it feels? _____
_____
6. QUALITY: ☐Burning ☐Diffuse ☐Dull/ Aching ☐Localized ☐Sharp ☐Shooting ☐Stabbing ☐Tingling ☐Radiating ☐Other: _____
7. Timing: ☐Worse AM ☐Worse PM ☐Worse Overnight ☐Worse with Activity ☐Intermittent ☐Constant
How often do you find yourself suffering from this problem? _____
How long does the problem last? _____
8. Please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible
What is your pain level at its best: _____
What is your pain level at its worst: _____

PATIENT NAME: _____ **DATE:** _____

CURRENT PERFORMANCE				
Caregiver- Child	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Caregiver- Adult	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Caregiver- Pet	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Carrying Groceries	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Climbing Stairs	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Driving	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Extended Computer Use	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Grooming	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Hobby:_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Household Chores	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Laundry	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Lifting Children	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Reading/ Concentrating	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Recreational Activity	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Self Care- Bathing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Self Care- Dressing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Self Care- Shaving	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sit to Stand	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Stand to Sit	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sitting	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Standing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sleep/ Laying Down	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sweeping	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Yard Work	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Vacuuming	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Walking	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Washing Dishes	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Work Duties	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform

CURRENT / PAST MEDICAL HISTORY	***Please date where appropriate**	
☐ AIDS / HIV	☐ Stomach Ulcers, Gastritis, Heartburn	☐ Pregnant (currently)
☐ Cancer (type)	☐ Hepatitis	☐ Pacemaker
☐ Lung Disease (type)	☐ Tuberculosis	☐ Headaches
☐ Stroke	☐ Anemia	☐ Seizures
☐ High Blood Pressure	☐ Coronary Heart Disease	☐ Recent Fractures
☐ Kidney Disease	☐ Heart Disease	☐ Dizziness / Fainting
☐ Thyroid Problems	☐ Open Heart Surgery	☐ Nausea / Vomiting
☐ Diabetes	☐ High Cholesterol	☐ Asthma / Breathing Problems
☐ Abdominal Surgery	☐ Numbness / Pins & Needles	☐ Latex Allergy
☐ Abdominal Aneurysm	☐ Osteoporosis	☐ Back / Neck: Aches/ Stiff/ Pain
☐ Fatigue	☐ Ringing/ Buzzing in Ears	☐ Bowel / Bladder Problems
☐ Sleeping Problems	☐ Loss of Smell / Taste	☐ Cold Hands / Feet
☐ Cold Sweats / Hot Flashes	☐ Depression	☐ Menstrual Pain / Irregularity
☐ Mood Swings / Irritability	☐ Lights Bother Eyes	☐ Loss of Balance

CURRENT MEDICATIONS/ VITAMINS/ SUPPLEMENTS ☐ See Below ☐ None

1. _____ Condition: _____ Since: _____
2. _____ Condition: _____ Since: _____
3. _____ Condition: _____ Since: _____
4. _____ Condition: _____ Since: _____
5. _____ Condition: _____ Since: _____
6. _____ Condition: _____ Since: _____

PATIENT NAME: _____ **DATE:** _____

PAST SURGERIES ☐ See Below ☐ None

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____ Year: _____
5. _____ Year: _____
6. _____ Year: _____
7. _____ Year: _____
8. _____ Year: _____

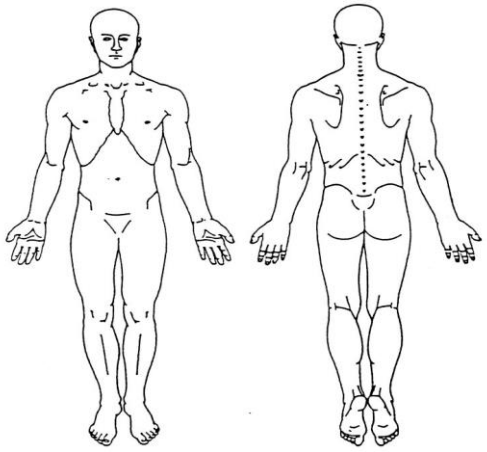
Area	Current Rating (0-10)	GOAL (0-10)	Frequency and Improvement
Head			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Neck			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Mid-Back			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Shoulder R / L			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Ribs			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Low-Back			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never

YOUR OPINION OF YOUR CURRENT HEALTH STATUS

1. On a scale of 0 to 100, with 1-59 being Very Challenged, 60-69 Challenged, 70-79 Transition, 80-89 Good, 90-100 Excellent, please rate yourself in the following areas:
   Where you believe your health is currently: _____
   Where you want it to be: _____
2. On a scale of 1 to 10, with 10 being the highest, rate your commitment to getting rid of the problem: _____
   What concerns do you have that may interfere with your commitment? (time, financial, transportation, etc.) Specify: _____
   _____
3. Recently, my tolerance for activity has been: ☐ Better ☐ Staying the same ☐ Worse
4. Activities that make my pain worse: _____
5. Activities that make my pain better: _____
6. Please rate your level of stress on a scale of 0-10, with 0 being no stress and 10 being extreme stress
   Occupational: _____
   Personal: _____
7. Rate the following as Good, Poor or Excellent
   Diet: _____
   Exercise: _____ What and how much: _____
   Sleep: _____ Hours per day: _____
   General Health: _____

Please indicate below where your symptoms are located. Use any / all symbols in the key as appropriate. Include all affected areas.

P = PAIN T = TINGLING N = NUMBNESS B = BURNING S = STIFFNESS O = SHARP PAIN A = ACHING



How did you hear about us:

☐ Doctor Referred ☐ Family / Friend _____ ☐ Public Event _____ ☐ Other: _____

BY SIGNING BELOW, I CERTIFIY THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Patient / Guardian Signature: _____ **Date:** _____

Relationship to Patient if Signed by Guardian: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cornerstone Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____🗀*Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ 🗀 *Witness Initials*

Patient or Authorized person's Signature Date

JDD,DC 5/2011