



Patient Health History

Today's Date Signature of Patient _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____ How did you hear about us? _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SSN _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Pregnant Yes No How many weeks _____

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Have you traveled out of the U.S. recently Yes No If yes, where _____

Verification Question (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
- What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
- What was the make of your first car? When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0
 - 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
- No interest* *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here:

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure
If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your spine in the past 28 days? Yes No

To be performed by clinic staff:

Height: _____ inches **Weight:** _____ pounds **BP:** ___ / ___

Describe Your Problem

(Fill in as necessary)

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptoms worse? (circle all that apply)
 - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other _____
- What makes the symptoms better? (circle all that apply)
 - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

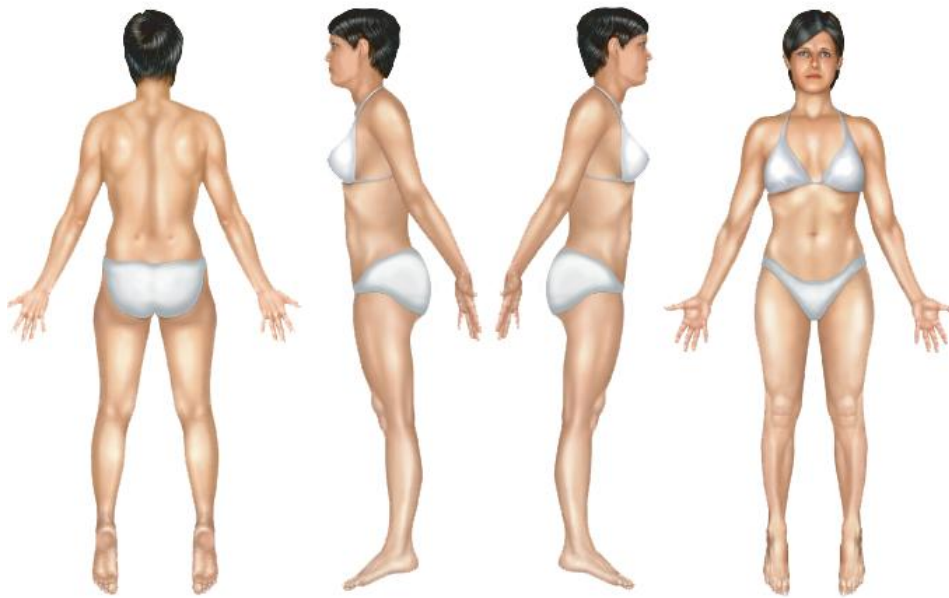
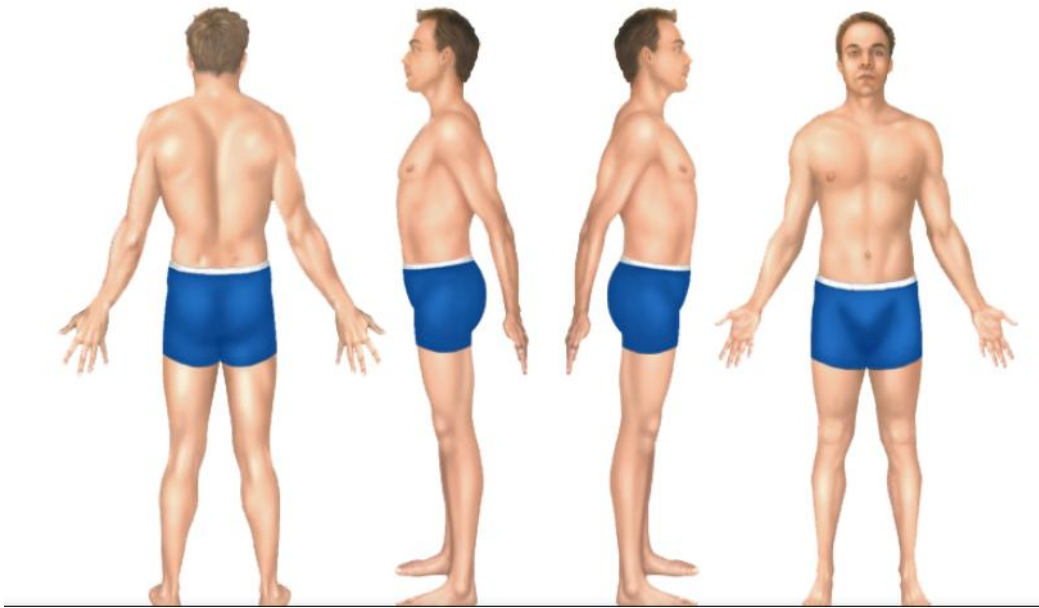
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptoms worse? (circle all that apply)
 - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other _____
- What makes the symptoms better? (circle all that apply)
 - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptoms worse? (circle all that apply)
 - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other _____
- What makes the symptoms better? (circle all that apply)
 - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptoms worse? (circle all that apply)
 - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other _____
- What makes the symptoms better? (circle all that apply)
 - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
 - Morning Afternoon Evening Night Unaffected by time of day



Body Diagram: Please indicate on the body where your symptoms are and what type of pain you are experiencing. Use the following to help describe the pain:

- | | |
|-------------|----------------------|
| N- Numbness | PN- Pins and Needles |
| B- Burning | D-Dull Ache |
| S- Stabbing | P- Pain |

FAMILY HISTORY: Do any Family Members have any of the following? Please indicate who has the condition.

Cancer _____	Clotting Disorder _____
Alzheimer's _____	Diabetes _____
Gastrointestinal Disorder _____	Heart Disease _____
High Cholesterol _____	Hypertension _____
Kidney Disease _____	Lung Disease _____
Osteoporosis _____	Psychological Disorder _____
Septicemia _____	Sudden Infant Death Syndrome _____
Stroke _____	
Any other serious illnesses not mentioned above: _____	

**Do you currently have or have you had:
(Please mark all that apply)**

NEUROLOGICAL

Current Past

Seizures		
Tremor		
Speech Problems		
Trouble Concentrating		
Headaches		
Muscle Weakness or paralysis		
Memory Loss		
Direct Head Trauma		
Loss of Consciousness		
Poor Coordination		
Numbness in groin		

MUSCULOSKELETAL

Current Past

Hernia		
Arthritis or Gout		
Bursitis		
Fractured Bones		
Pain fails to improve with rest		
Pain greater than 4 weeks		
History of Osteoporosis		

CARDIOVASCULAR

Current Past

Passing Out		
High Cholesterol/ Triglycerides		
Chest pain		
Heart Disease or Murmur		

ENDOCRINE

Current Past

Diabetes		
Thyroid Trouble		
Liver Trouble		

INTEGUMENTARY/ALLERGIC

Current Past

Skin Conditions		
Hay Fever		
Shingles		

HEMATOLOGIC

Current Past

Anemia		
Bleeding or Bruising Tendency		

ENT

Current Past

Sinus Problems		
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CONSTITUTIONAL

Current Past

History of Trauma		
Infection		
Unexplained Weight Loss		
Unusual Fatigue		
Dizziness/Poor Balance		
Change in Appetite		
Fevers/Night Sweats		
Low or High Blood Pressure		
History of Cancer		
Abdominal Pain		
Use of Corticosteroids		
Use of Anticoagulants		
Blood Clots		
Use of Birth Control		
Intravenous Drug Use		
Stroke		

RESPIRATORY

Current Past

Asthma		
Shortness of Breath		
Chronic Cough		
Difficulty Breathing		

URINARY

Current Past

More Frequent Urination		
Pain or Blood in Urination		
Kidney or Bladder infection		
Kidney Stones		

GASTROINTESTINAL

Current Past

Recurrent Abdominal Pain		
Nausea		
Ulcers		
Heartburn		
Diarrhea or Constipation		
Hemorrhoids		
Loss of Bowel		
Loss of Bladder Control		
Vomited Blood		
Bloody or Black Stools		
Celiac Disease		

Cancellation Policy: We require a 24-hour cancellation for all of our services. Failure to do this will result in a cancellation fee.

Patient Signature: _____



HIPAA Privacy Authorization Form/ Notice of Privacy Practices

Authorization of use or disclosure or protected health information

(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164)

Please read the follow and sign at the bottom:

I hereby authorize ADIO Chiropractic Center to view radiology studies that are necessary for my treatment. Requests for other studies and medical information will require a separate request form and my signature. I understand that these studies may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Hum Immunodeficiency Virus (HIV) and other communicable diseases. Behavioral Health Care/ Psychiatric Care, Treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes the release of any such information.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, and/ or other purposes as I may direct.

This authorization shall be in force and in effect until I sign a written request to terminate this agreement. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re- disclosed by the person or organization that received the information.

I release ADIO Chiropractic Center, its employees, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

By signing below you agree to the statements presented.

If you would like us to disclose your medical records, upon request, to any addition parties (i.e.; spouse, parent, providers) please provide Name, Date of Birth and Relationship:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

WITNESS SIGNATURE

DATE