

Carnegie Chiropractic, P.C.

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Practice Member Health Assessment

Please fill in ALL parts completely. Thank You!

EMAIL ADDRESS: _____ Date: _____

Name: _____ Social Security # (for insurance purposes): _____-_____-_____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Weight: _____ Marital Status: (circle) M S W D LP # of Children: _____

Home Telephone: _____ Work Telephone: _____ Ext: _____ Cellular: _____

Occupation: _____ Employer: _____

Employer Address: _____

Spouse's Name: _____ Occupation: _____ Work Telephone _____ Ext: _____

Whom may we thank for referring you?: _____

• Primary reason for your visit today?: Spinal Check-Up Current Complaint: (explain): _____
_____ Date of onset: _____

• Have you ever been under Chiropractic Care? Yes No By Whom? _____

• How did your problem begin? Gradual Sudden Car Accident Work Injury Personal Injury
 Sports Injury Other _____

• Have you had this or similar condition in the past? Yes No If YES, when: _____

• What treatment have you received for your condition? Medication Surgery Chiropractic Care
 Physical Therapy None Other _____

• What medications are you taking? _____

• Please indicate areas of Pain below:

• How often is the complaint present?

Constant (80-100%) Frequent (50-80%)
 Occasional (25-50%) Intermittent (25% or less)

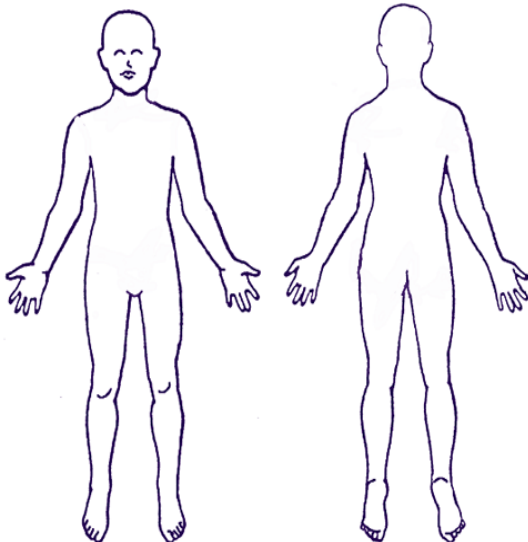
• How would you rate the intensity? (circle the appropriate number)
0 1 2 3 4 5 6 7 8 9 10
(mild discomfort) (moderate discomfort) (unbearable)

• Since the problem began, is your complaint getting:
 Better Worse Unchanged

• What activities aggravate this condition? (please check all that apply)
 Excessive Sitting Excessive Standing Stress
 Walking Running Exercise Bike Riding
 Daily Activities (explain) _____
 Bending House Cleaning Other _____

• Does this condition interfere with your? (please check all that apply)
 Work Sleep Daily Routine Other (please explain)

Numbness Pins and Needles Burning Aching Stabbing
----- oooo ^^^^ xxxx ****



- Please list all surgical operations and years they were performed. (If none, check box)

- Date of last Physical Examination: _____ By Whom: _____

- **Women:** Are you pregnant at this time? **YES** **NO** *If **NO**, I give the doctor and his/her associates my permission to perform an x-ray evaluation, if needed. I understand that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____ Signature: _____

- Past and Present Conditions

| | Past | Present | | Past | Present |
|-----------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Condition of Uterus or Ovaries | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Prostate condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| General Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Skin conditions | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart condition | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory condition | <input type="checkbox"/> | <input type="checkbox"/> | Allergies/ Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive condition | <input type="checkbox"/> | <input type="checkbox"/> | Sinus condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Menstrual problems | <input type="checkbox"/> | <input type="checkbox"/> | Kidney/ bladder problems | <input type="checkbox"/> | <input type="checkbox"/> |

- Age of Mattress: Less than 6 months More than one year More than 5 years Do not know

- **Family History:** Many health problems are a result of hereditary spinal weaknesses; thus information concerning your family will give us a better understanding of your total health picture.

| Family Member | Relation | Present Health Problems |
|---------------|----------|-------------------------|
| | | |
| | | |
| | | |
| | | |

- **Communication Channels:**

I remember important things in my life by: What I hear What I see What I feel

The primary reason I brush my teeth is to: Avoid tooth decay and gum disease Make sure I have healthy teeth and gums

When I make decisions I generally: Gather facts and weigh the evidence Make the right choice instantly
 Consult my friends and family Depend upon how I "feel" about it

- **Insurance Information:**

- Do you have health insurance? **YES** **NO** If **YES**, please present your insurance card to the reception area in order for the staff to make a copy for our records. Thank you.

- Does **Medicare** cover you? **YES** **NO** If **YES**, please provide your Medicare Card #: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I understand that this Chiropractic Office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____