CARNEGIECHIROPRACTIC 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: _____ Height:_____ 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:

Numbness	*Pins and Needles*	*Burning*	*Aching*	*Stabbing*
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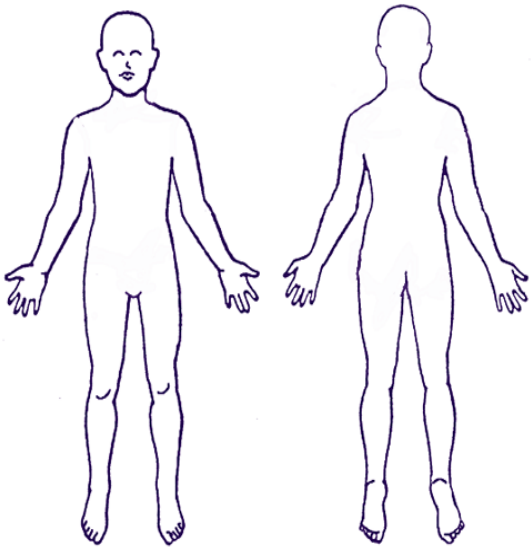

● How often is the complaint present?
□ Constant (80-100%) □ Frequent (50-80%)
□ Occasional (25-50%) □ Intermittent (25% or less)

● 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)
_____

● 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	□	□	Condition of Uterus or Ovaries	□	□
Dizziness	□	□	Prostate condition	□	□
Fainting Spells	□	□	Diabetes	□	□
Convulsions	□	□	Arthritis	□	□
General Fatigue	□	□	Skin conditions	□	□
High Blood Pressure	□	□	Stroke	□	□
Heart condition	□	□	Cancer	□	□
Respiratory condition	□	□	Allergies/ Asthma	□	□
Digestive condition	□	□	Sinus condition	□	□
Menstrual problems	□	□	Kidney/ bladder problems	□	□

● 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: _____