Gartner Chiropractic

Date:_____

Patient Contact Information:

Title: Mr/Mrs/Ms/Dr/Rev/Rank_____

Last Name_____ First Name_____ M.I._____ Nickname_____

Address _____ City_____ State_____ Zip_____

Home Phone_____ Secondary Phone_____

Mobile Phone_____

Home Email_____ Work Email_____

Which email address would you like us to communicate with you? (circle one) **Home / Work**

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

Patient Personal Information:

Date of Birth_____ Age_____ Gender: **Male** **Female**

Social Security #: _____

Employment status : **Employed** **FT student** **PT student** **Retired** **Self-employed** **Other**

Marital status: **Single** **Married** **Other**

Spouse Name_____ Date of Birth_____

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

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

Verification Question *(choose only one question by checking the box, then give the answer to that question) This information will be used when sending you confidential, HIPAA-protected health information.*

❑ 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? ❑ What is your favorite color?

Verification Answer to the chosen question:_____

Emergency Contact:

Name_____ Relationship_____

Home Phone_____ Mobile Phone_____

Gartner Chiropractic

Most patients are referred out our office by a caring family member or friend. What made you decide to visit out office?

Friend or family member name_____

Yellow Pages Website Presentation Sign Newspaper Other:_____

Have you ever received Chiropractic care? **Yes No**

If yes, when and where?_____

Who is your Primary Care Physician? _____ Last Visit_____

Patient Case History

I. Health Complaints

□ I have no health complaints, I am interested in prevention and health maintenance (skip to section II)

What is your **primary** complaint? _____

List other health complaints on the following lines:

2 _____ 3 _____

4 _____ 5 _____

6 _____ 7 _____

How long have you been experiencing the **primary** complaint? _____

How does the **primary** complaint feel? □ dull □ sharp □ numb □tingling □burning □spasm □other_____

How often do you experience the **primary** complaint? □ constantly □ daily □ weekly □ monthly □ yearly

What makes your **primary** complaint better? _____ worse? _____

Have you missed any work or school because of your **primary** complaint? □ yes □ no

How does your **primary** complaint affect you at home/work/school? _____

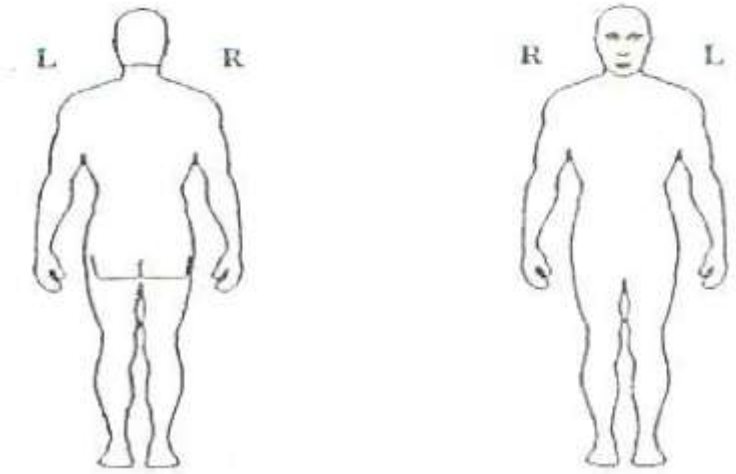
Have you had any prior treatment for your **primary** complaint? _____

What do you believe is causing your **primary** complaint? _____

Please mark the areas of all of your complaints on the diagrams to the right.

Please rate your pain today on a scale of 0 (no pain)to 10 (excruciating)

0 1 2 3 4 5 6 7 8 9 10



II. Health History

Are you pregnant? **Yes** **No** If yes, how many weeks? _____

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

No interest *Very Interested*

How many servings of alcohol do you drink each week? □ 0 □ 1-2 □ 3-5 □ 6-9 □ 10-20 □ >20

How many servings of coffee do you drink each week? □ 0 □ 1-2 □ 3-5 □ 6-9 □ 10-20 □ >20

How many servings of soda do you drink each week? □ 0 □ 1-2 □ 3-5 □ 6-9 □ 10-20 □ >20

How many glasses of water do you drink each day? □ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9+

How many times do you eat per day? □ 1 □ 2 □ 3 □ 4 □ >5

How often do you exercise? □ daily □ 5x/week □ 4x/week □ 3x/week □ 2x/week □ 1x/week □ I don't exercise

How long do your workouts last? □ <30 minutes □ 30 minutes □ 1 hour □ >1 hour

What are your exercise activities?

□ walking □ swimming □ weight lifting □ stretching/flexibility □ resistance bands

□ running/treadmill/rowing □ yoga/Pilates □ group exercise classes □ other

Please mark any of the following that apply to you:

□ Headaches	□ Wrist/Hand Pain	□ Hepatitis	□ Low Back Pain
□ Seizures	□ Upper Back	□ Gallbladder Removed	□ Hip Pain
		□ Diabetes	
□ Multiple Sclerosis	□ Mid Back Pain	(***Type I or Type II***)	□ Knee Pain
□ Visual Problems	□ Asthma	□ Anemia	□ Ankle/Foot Pain
□ Allergies/Sinus	□ Chest Pain	□ Irritable Bowel Syndrome	□ Cancer
□ Ringing In Ears	□ High Cholesterol	□ Digestive Problems	□ Arthritis
□ Neck Pain	□ High Blood Pressure	□ Constipation	□ Autoimmune Disease
□ Hypothyroidism	□ Acid Reflux/Indigestion	□ Hemorrhoids	□ Fibromyalgia
□ Shoulder Pain	□ Muscle Spasms/Cramps	□ Menstrual Issues	□ Weight (loss or gain)
□ Elbow Pain	□ Ulcers	□ Urinary Difficulties	□ Other:____

III. Hospitalization, Surgeries and Injuries

Do you have a pacemaker?	□ yes	□ no
Have you had knee or hip replacement surgery?	□ yes	□ no
Do you have any other implantable medical device in your body?	□ yes	□ no

Please list any hospitalizations, surgeries or injuries that you have had (if none, write NONE):

	Date	Description
1		
2		
3		
4		
5		

IV. Current medications and Allergies

Please include 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 or environment. Please include what reaction took place.

If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

V. Genetic History

Have any of your blood relatives had any of the following conditions? If yes, please list who (if none, write NONE).

Heart Disease _____ Stroke _____

Cancer _____ Arthritis _____

Diabetes _____ Auto-Immune Disease _____

What types of care are you seeking? (mark all that apply)

□ Injury prevention	□ Nutritional and supplement counseling	□ Health education classes
□ Balance and coordination training	□ Spinal and body alignment	□ Treatment for pain
□ Range of motion, mobility, or flexibility therapy	□ Strengthening and stamina exercise	□ Other _____

_____ _____

Patient or guardian signature Date