Wexford Chiropractic Centre

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Full Name _____ Date _____

Mailing address _____
Street City State Zip

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ **Email** _____

Spouse/Guardian Name _____ Occupation _____

Marital Status: M S W D Age _____ Birth date _____ No. of children _____

Pregnant?_____ Height _____ Weight _____ Occupation _____
Do you have Health Insurance? Yes_____ No_____
If "Yes", what is the name of the company? _____
Do you have Medicare Coverage? Yes_____ No _____

WHO MAY WE THANK FOR REFERRING YOU? _____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:
If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General History"** section

I. HEALTH CONCERNS

List health concerns According to their severity Present	Rate of severity **1mild 10 worst imaginable**	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is
1.					
2.					
3.					
4.					

What have you done for this condition? Was it of benefit?
_____
_____

I do (do not) have a family history of this or similar symptoms (Please explain)
_____
_____

What activities aggravate your condition? _____
_____
_____

Other Doctor's seen for this condition:
Chiropractic Dr. _____ Medical Dr. _____ Other _____

1. Name/Address: _____
When: _____ What did they say was wrong? _____
What did they do? _____ Did it help? _____
2. Name/Address: _____
When: _____ What did they say was wrong? _____
What did they do? _____ Did it help? _____

Is this condition interfering with your: work____ sleep____ daily routine____ sports/exercise____

GENERAL HEALTH HISTORY SECTION

Have you had any surgery? (Please include all surgery)

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type_____ When_____ Hospitalized ____Yes ____No
2. Type_____ When_____ Hospitalized ____Yes ____No
3. Type_____ When_____ Hospitalized ____Yes ____No

Have you ever had x-rays taken? _____ When?_____ Where?_____
Area of body:_____
Do you wear orthotics or heel lifts? Yes_____ No_____

CURRENT MEDICINE(S)/SUPPLIMENTS:

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

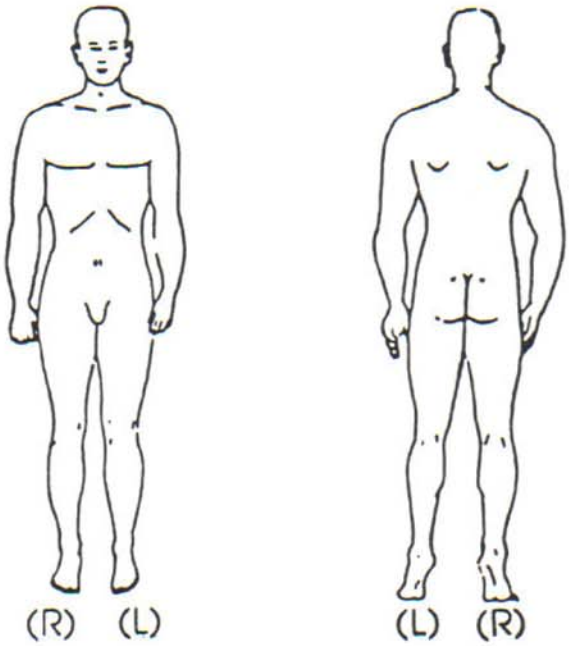
Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

_____

PLEASE MARK YOUR AREAS OF PAIN BELOW



HABITS:	Heavy	Moderate	Light	None
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Soda	____	____	____	____
Sugar	____	____	____	____
Artif. Sweetnr.	____	____	____	____
Fried Foods	____	____	____	____
Drugs	____	____	____	____
Exercise	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____

PAST HEALTH HISTORY

Mark the following conditions you may have had or have now
(- have had + have now)

___ Allergy	___Diarrhea	___Fatigue
___ Difficulty Breathing	___Stroke	___Anemia
___Arteriosclerosis	___Emphysema	___Itching
___High Blood Pressure	___Asthma	___Nervousness
___Heart Disease	___Depression	___Convulsions
___Headaches	___Pneumonia	___Arthritis
___Gall Bladder Problems	___Migraines	___Constipation
___Irregular Periods	___Diabetes	___Dizziness
___Low Blood Sugar	___Heart Attack	___Joint Pain
___Menstrual Cramps	___Alcoholism	___HIV (Aids)
___Multiple Sclerosis	___Sinus Problems	___Cancer
___Thyroid Problems	___Chronic Colds	
___Pleurisy		
___Epilepsy	___Eye Problems	___Eczema
___Low Back Pain	___Nose Problems	___Ulcers
___Neck Pain	___Ear Problems	___Foot Pain
___Other (Please Explain)		

_____

_____

_____

_____

_____

_____

_____

TINGLING OR NUMBNESS IN:

___Shoulder	___Hips
___Arms	___Legs
___Elbows	___Knees

How do you grade your physical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

How do you grade your emotional/mental health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?

YES _____ NO _____ MAYBE _____

If dietary changes are indicated would you be willing to make changes in your diet?

YES _____ NO _____ MAYBE _____

Would you take whole food supplements if indicated?

YES _____ NO _____ MAYBE _____

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____

_____

PRIMARY CARE PHYSICIAN NAME_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me 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 on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Payment is expected at time of visit.

Name of person responsible for payment_____

Patients Signature _____ Date: _____

Guardian or Spouses Signature _____