CONFIDENTIAL PERSONAL HISTORY
(PLEASE PRINT)

E-MAIL _____ DATE: _____

SSN# _____

NAME: _____ MARITAL STATUS: M S W D SEX: M F

ADDRESS: _____, APT#_____

CITY, STATE: _____ ZIP: _____

HOME PHONE: _____ WK PHONE: _____ CELL PHONE:_____

BIRTH DATE: _____ AGE: _____ NO. OF CHILDREN: _____

OCCUPATION/ PROFESSION: _____ EMPLOYED BY: _____

NAME OF SPOUSE: _____ EMPLOYED BY: _____

REFERRED BY: _____

HOW DID YOU HEAR ABOUT US:_____

PATIENT'S NEAREST RELATIVE: _____, PHONE: _____

PREVIOUS CHIROPRACTIC CARE: YES ____ NO____ IF YES, W/WHOM?_____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

What is the main reason for your visit today? _____
_____

CAUSE: _____ DATE OF ONSET: _____

TREATMENT THUS FAR FOR THIS COMPLAINT: _____

What are your most important health problems? List as many as you can in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

HISTORY: (I.E. INJURIES, AUTO ACCIDENT, ETC.) (EXPLAIN): _____

_____

PUT AN X IN FRONT OF THE FOLLOWING ILLNESSES WHICH YOU HAVE HAD:

___ MEASLES	____ PNEUMONIA	_____ GONORRHEA	_____ NERVOUSNESS
___ MUMPS	____ PLEURISY	_____ SYPHILLUS	_____ NERVIOUS BREAKDOWN
___ CHICKEN POX	____ TUBERCLULOSIS	_____GALL STONES	_____ "LEAKING" HEART (MURMURS)
___ SMALLPOX	____ ARTHRITIS	_____ KIDNEY STONES	_____ RHEUMATIC FEVER (CHOREA)
___ DIPTHERIA	____ DIABETES	_____ KIDNEY DISEASE	_____ HEPATITUS OR JAUNDICE
___ WHOOPING COUGH	____ GOITER	_____ CANCER	_____ HIVES OR ECZEMA
___ POLIO	____ MIGRAINE	_____ MENINGITIS	_____ ANY BONE OR JOINT DISEASE
___ SCARLET FEVER	____ ANEMIA	_____ EPILEPSY	_____ LOW BLOOD PRESSURE
___ HAY FEVER	____ FRACTURES	_____HEART DISEASE	_____ HIGH BLOOD PRESSURE
___ ALLERGIES	____ ASTHMA	_____ OTHER, DESCRIBE: _____	

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations or surgeries, X-rays, CAT scans, MRI, EEG, EKG's have you had?

_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____
_____year:_____	_____year:_____

CURRENT MEDICATIONS

Do you take or use? (please circle and list how long)

Laxatives _____Pain relievers _____Antacids _____

Cortisone _____Appetite suppressants _____Antibiotics _____

Tranquilizers/Sleeping pills _____Thyroid medication _____

Birth control pills/ Hormones_____

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking and for what:

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

FAMILY HISTORY – PUT AN X IN FRONT OF THOSE WHICH APPLY:

RELATIVE	LIVING	DEAD	CANCER	T.B.	DIABETES	BLOOD DI	ALLERGY	HEART	ARTHRITIS	OTHER
FATHER										
MOTHER										
SISTERS										
BROTHERS										

PUT AN "X" IN FRONT OF THE FOLLOWING WHICH PRESENTLY APPLY:

EYES
____ DOUBLE VISION
____ GLASSES
____ TEARING
____ BURNING
____ EYE STRAIN

EARS
____ DEAFNESS
____ DISCHARGE
____ RINGING
____ EXCESS WAX

SKIN
____ RASHES
____ ERUPTIONS
____ DISCOLORATIONS

WEIGHT
____ GAIN
____ LOSS
____ HOLD THE SAME

NOSE
_____ SINUSITIS
_____ BLEEDING
_____ POST NASAL DRIP
_____ OBSTRUCTION

THROAT
_____ SORENESS
_____ HOARSENESS
_____ DIFFICULTY SWALLOWING

HEAD
_____ HEADACHES
_____ TRAUMA
_____ DIZZINESS
_____ FAINTING

CHEST
_____ PAIN
_____ HEART POUNDING
_____ DIFFICULT BREATHING
_____ COUGH UP-BLOOD / SPUTUM

MUSCULAR
_____ NUMBNESS
_____ JOINT PAIN
_____ VARICOSTITIES
_____ SWELLING OF HANDS/FEET

URINARY (URINATION)
_____ ABNORNALLY FREQUENT
_____ BURNING
_____ PAIN
_____ COLORED W/ BLOOD OR PUS
_____ EXCESSIVE THIRST

FEMALE (ONLY)
_____ PERIODS IRREGULAR
_____ PERIODS REGULAR
_____ DURATIONS OF PERIODS
_____ # OF PREGNANCIES
_____ COMPLICATIONS DURING PREGNANCY
_____ MENOPAUSE
_____PCOS/ENDOMETRIOSIS

DIGESTIVE
____ NO APPETITE
____ NAUSEA
____ VOMITTING
____ BELCHING
____ DIARRHEA
____CONSTIPATION
___IRREGULAR STOOL
____ RECTAL BLEEDING
____ HERNIA
_____ ULCERS

HABITS
____ COFFEE
____ TEA
____ MILK
____ WATER
____ SODAS
____ALCOHOL
____CIGARRETES
____ DRUGS
____ OTHER

ENDOCRINE
____COLD INTOLERANCE
____HEAT INTOLERANCE
____INCREASE LOSS OF HAIR
____THYROID DISEASE

HEIGHT_____ WEIGHT_____

FEMALES ONLY: ARE YOU PREGNANT? YES _____ **NO** _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

PERSON RESPONSIBLE FOR PAYMENT: _____

WILL WE BE FILING ON YOUR INSURANCE? _____YES _____NO

COMPANY: _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT **KINGWOOD CHIROPRACTIC** WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO **KINGWOOD CHIROPRACTIC** 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.

PATIENTS SIGNATURE: _____ DATE: _____

GUARDIAN OR SPOUSE'S SIGNATURE: _____ DATE: _____