



HEALTH HISTORY

Who is your Medical Doctor? _____ Phone #: _____

May we have your permission to contact your doctor? Yes No

Are you taking any: Prescription Drugs (please list) _____

Over the Counter Drugs (please list) _____

Recreational Drugs (please list) _____

Do you have or have you ever had any of the following conditions?

Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N STD	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition (s) you have or ever had: _____

Please list anything to which you may be allergic: _____

List previous surgeries/treatments with dates: _____

List any past accidents, injuries or broken bones with dates: _____

Family Health History: _____

Do you take supplements or vitamins? Yes No Do you exercise? Yes No

What is your current weight: _____ lbs., and height: _____ feet _____ inches

Are you on a special diet? No Yes Since: ____/____/____ Type: _____

Do you smoke? No Yes How much? _____ How Long? _____

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

What is the age of your mattress? _____ Is it comfortable? Yes No

For Women: Are you taking Birth Control? Yes No

Are you pregnant? No Yes/How many weeks? _____ Are you nursing? Yes No



AUTO RELATED ACCIDENT

Date & Time of Accident: _____ a.m. p.m.

Where you the: Driver Front Passenger Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

Was the accident a surprise or did you see it coming? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ... Yes No

Was a police report filed?..... Yes No

Were there any witnesses?..... Yes No

Were you wearing your seatbelt?..... Yes No

Was the vehicle equipped with airbags?..... Yes No

If yes, did they/it inflate?..... Yes No

In relation to the base of your skull, where was the headrest? Above Below At base of skull

What did your vehicle impact? Another vehicle Other... If other please explain: _____

Did any part of your body strike anything in the vehicle? Yes No...

If yes, please explain: _____

Make and model of the vehicle you were occupying? _____

Name of the location/street you were traveling? _____

In which direction were you headed? N S E W

What was the approximate speed of your vehicle? _____

AFTER INJURY

Did the accident render you unconscious? Yes No

If Yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to the hospital or seen any other doctor? Yes No

When did you go? Just after accident The next day 2 days +



AFTER INJURY CONT.

Name of Hospital and/or Attending doctor: _____

Describe any treatment you received: _____

Were X-rays taken:..... Yes No

Was medication prescribed?..... Yes No

Have you been able to work since the injury?..... Yes No

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

Dizziness Difficulty Sleeping Jaw Problem Nausea Other

Memory Loss Irritability Arms/Shoulder Pain Back Pain Numb feet/toes

Headaches Fatigue Numb hands/fingers Lower back pain Upset

Stomach

Blurred Vision Tension Chest Pain Back stiffness Stiff neck

Buzzing in ears Neck Pain Shortness of breath Leg pain Ear ringing

is your condition getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete following:

How many hours are in your normal work day? : _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Crawling |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Operating equipment |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Typing | <input type="checkbox"/> Stopping |
| <input type="checkbox"/> Other: _____ | |

Prior to the injury were you capable of working on an equal basis with others your age ? Yes No

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- ◆ I authorize the staff of Slak Chiropractic Group to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
 Adult Patient Parent or Guardian Spouse