

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ Birth Date: _____ Age: ____ Sex: M F
Home Phone: _____ Cell Phone: _____ E-mail Address: _____
Employer: _____ Type of Work: _____ Business Phone: _____
Name of Spouse: _____ Spouse's Social Security#: _____
Spouse's Employer: _____ Type of Work: _____
Business Phone: _____ Name and Ages of Children: _____
Referred to Our Office By: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who is Responsible for Your Bill, You and Spouse Worker's Comp Auto Insurance
 Medicare Medicaid Name of Insurance Company: _____
Insured Person's Name: _____ Date of Birth: _____

CURRENT HEALTH CONDITION

Reason For Consulting Dr. Johnson: _____
Other Doctors Seen For This Condition: Yes No Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
Is Condition? Work Injury Home Injury Auto Accident Fall Other _____
Date of Accident _____ Time of Accident _____
Have You Made a Report of Your Accident to Your Employer? Yes No
Drugs You Now Take: Nerve Pills Pain Killers Muscle Relaxants Blood Pressure Medicine
 Insulin Birth Control Other: _____
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia
 Back Surgery Broken Bones Other _____
Major Accidents, Injuries or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Yes, Doctor and Date of Last Visit _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Disease | Intake |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Influenza | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> White Sugar |

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculo-skeletal

- Low Back Pain
- Pain Between the Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Jaw Clicks/Grinds
- General Stiffness

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling hands
- Cold/Tingling feet
- Stress

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

Gastro-Intestinal

- Poor Appetite

- Excessive Appetite
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating
- Heartburn
- Black/Bloody Stool
- Colitis

Genitourinary

- Bladder Trouble
- Excessive Urination
- Discolored Urine

Cardiovascular

- Chest Pain
- Short Breath
- High Blood Pressure
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems

- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Sinus Problems

Male/Female

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Problems
- Sexual Dysfunction
- Other Problems
- _____

Females Only:

When was your last period? _____
 Are you pregnant?
Yes No Not Sure

Family History

The following members of my family have the same or similar problems as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

Please check the type of care desired, so that we may be guided by your wishes whenever possible.

- Relief Care (pain relief)
- Corrective Care (relief of pain and correction of the cause of the problem)
- Check here if you want Dr. Johnson to select the type of care appropriate for your condition.