GREAT BASIN CHIROPRACTIC

Confidential Patient Information

Date _____

Name _____

DOB _____ sex (M or F) ____Marital Status _____ Home Phone_____

Adress_____City_____State_____Zip code_____

Social Security#_____ Work # _____Employer/Location _____

Spouse's name _____ Social Security# _____Employer/Location _____

Race; American Indian or Alaska Native, Asian, Black or African American, Caucasian, Hispanic, Native-Hawaiian or Other, Pacific Islander, White, Decline-to specify.

Ethnicity; Hispanic or Latino, NOT Hispanic or Latino Preferred Language _____

If not married, name of nearest relative

_____

Who referred you to our office? _____

Do you have Insurance? Yes __ or No __ Insurance Company _____

ID # _____ Policy Group # _____

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Great Basin Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctor at Great Basin Chiropractic and whomever they may designate as their assistants, to administer treatment as they so deem necessary and, also the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct. **Great Basin Chiropractic Clinic also understands the patient's privacy and there will not be any release of information unless authorized by you the patient.**

Patient's (Parent or Guardian's) Signature _____

Is your visit due to an auto accident or work- related injury? Yes ____ No ____

YOUR PRESENT COMPLAINT _____

Briefly describe your symptoms _____

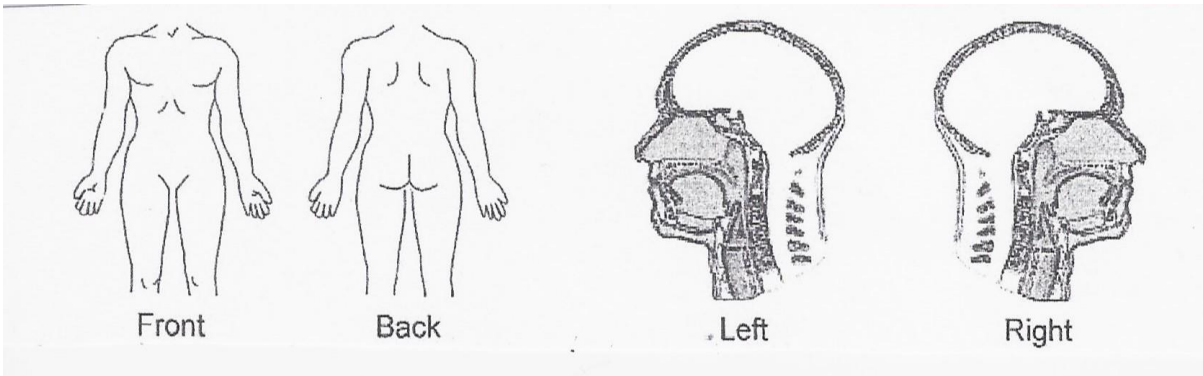
Circle One – is the pain sharp stabbing dull achy other does it radiate anywhere? Yes / No _____

How long have you had this pain? _____

List any doctor(s) seen for this condition _____

229 N. Egan Ave Burns, Ore 97720 (541)573-7733 Fax (541)573-7732

Mark area of complaint on diagram below: use P=pain, S=spasms, N=numbness, T=tingling



Musculo-Skelatal

Circle any of the following you have experienced other than your current major complaint(s):

Low back pain	Past	Prsnt	/	Mild	Mod	Svr	Leg pain/weak/numb	Past	Prsnt	/	Mild	Mod	Svr
Pain between shoulders	Past	Prsnt	/	Mild	Mod	Svr	General stiffness	Past	Prsnt	/	Mild	Mod	Svr
Neck problems	Past	Prsnt	/	Mild	Mod	Svr	Fractures	Past	Prsnt	/	Mild	Mod	Svr
Arm pain/weak/numb	Past	Prsnt	/	Mild	Mod	Svr	Foot/ankle problems	Past	Prsnt	/	Mild	Mod	Svr
Joint pain/stiffness	Past	Prsnt	/	Mild	Mod	Svr	Difficulty chewing/clicking jaw	Past	Prsnt	/	Mild	Mod	Svr
Walking problems	Past	Prsnt	/	Mild	Mod	Svr	Knee problems	Past	Prsnt	/	Mild	Mod	Svr
Muscle cramps	Past	Prsnt	/	Mild	Mod	Svr	Hip problems	Past	Prsnt	/	Mild	Mod	Svr

General

☐ **Cold and tingling extremities:** ☐ Hands ☐ Feet ☐ Both, Date of onset _____

☐ Fatigue ☐ Past ☐ Present Mild / Moderate / Severe Daily? Yes ☐ No ☐ Is there a pattern? (describe) _____

☐ **Hair loss** Yes ☐ No ☐

Headaches ☐ Past ☐ Present If present, how long? _____

Degree: ☐ Mild ☐ Moderate ☐ Severe Is there a pattern? (describe)

_____

How long has this pattern of headaches existed? (days, months, years, etc.) _____

Do you have any idea of what causes or triggers your headaches? _____

Females only…. Is there a relationship to your menstrual cycle? ☐ Yes ☐ No

Disease – Check any of the following that you have had or currently have

☐ Aides/HIV	☐ Eczema	☐ Influenza	☐ Rheumatic Fever
☐ Anemia	☐ Epilepsy/Seizures	☐ Measles	☐ Scarlet Fever
☐ Asthma	☐ Fibromyalgia	☐ Mental Disorder	☐ Small Pox
☐ Arthritis	☐ Genital Warts	☐ Muscular Dystrophy	☐ Thyroid
☐ Cancer	☐ German Measles/Rubella	☐ Muscular Sclerosis	☐ Tuberculosis
☐ Chemical Sensitivity	☐ Heart Disease	☐ mumps	☐ Venereal Disease
☐ Chicken Pox	☐ Hemophilia	☐ Pneumonia	☐ Whooping Cough
☐ Concussion	☐ Hepatitis	☐ Polio	
☐ Diabetes	☐ Herpes	☐ Pleurisy	

Have you ever been treated for any other condition not covered above? (describe)

_____

_____

_____

Describe any operations you've had and the dates.

_____

_____

_____

Have you been treated by a physician for any health condition in the past year? Describe condition

_____

Are you taking medications? ☐ Yes ☐ No

What kind? _____

Are you allergic to any medication? ☐ Yes ☐ No

What kind? _____

Check any of the following you have experienced <u>other than your current major complaint(s):</u>

Nervous System

☐ **Nervousness:** Do you consider yourself to be a nervous type in general? _____

Are you feeling nervous about something specific? _____

☐ **Forgetfulness:** Are you forgetting recent events? _____

Events from the past? _____

Do you forget other things? _____

Is your memory worse with stress? _____

☐ **Numbness:** Where? _____ Onset _____

Frequency: ☐ occasional ☐ intermittent ☐ constant

☐ Dizziness ☐ Past ☐ Present

☐ Fainting ☐ Past ☐ Present

☐ Stress ☐ Past ☐ Present

If present, what areas of your life do you consider to be stressful? _____

Depression: ☐ Past ☐ Present If present, how long have you been depressed? _____

Have you taken prescribed medication for depression? ☐ Yes ☐ No

If yes, list medication: _____

Are you getting professional counseling? ☐ Yes ☐ No

Is your depression Mild ☐ Moderate ☐ Severe ☐

Is there family history of depression? ☐ Yes ☐ No

Eyes, Ears, Nose & Throat

☐ **Vision Problems** ☐ Past ☐ Present Specify problem _____

List treatments _____

☐ **Sore Throat** ☐ Past ☐ Present If present, when did it begin? _____

What do you think caused or influenced this condition? _____

List any treatment and its effectiveness: _____

☐ **Nose/Sinus problems** ☐ Past ☐ Present

Describe: _____

When did it begin? _____ How severe is it? _____ What do you think cause or influenced this condition? _____ List any treatment and its effectiveness: _____

☐ **Noise in the ear** ☐ Past ☐ Present Describe _____
When did it begin? _____ How severe is it? _____
What do you think cause or influenced this condition? _____

Allergies List known allergies: _____

How often? Daily / Weekly / Monthly / occasionally, which season? _____
What kind of symptoms do you have with your allergies? _____

Nose Bleeds ☐ Past ☐ Present How often? _____

Sleep Habits Average hours per night _____

☐ **Loss of sleep** ☐ Past ☐ Present How frequent?_____
When did this begin? _____
Do you have difficulty falling asleep or staying asleep? ☐ Yes ☐ No What factors do you think cause or influence this condition? _____

Skin Conditions ☐ Past ☐ Present
Describe condition_____
List any treatment and its effectiveness: _____

Fever When was your last fever? _____ How often do you get fevers? _____

Low/High Blood Pressure Describe your condition_____

Genito-Urinary

☐ **Bladder Infections:** When was the last one? _____ How often do you get one? (per year) _____
What factors do you think causes or influences this condition? _____

☐ **Discolored urine** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Incontinence** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Dribbling** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Blood in urine** ☐ Past ☐ Present If present, when did it begin? _____

Cardiovascular/Respiratory

☐ **Chest pain** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Shortness of breath** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Heart disease** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Ankle swelling** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Blood pressure problems** ☐ Past ☐ Present If present, when did it begin? _____
☐ **Lung problems/congestion** ☐ Past ☐ Present Describe_____
☐ **Stroke** ☐ Past ☐ Present How severe? _____
☐ **Chronic cough** when did it start? _____ Are you a smoker? ☐ Yes ☐ No ☐
Irregular heartbeat/murmurs: (circle one or both) Describe
_____ Have you seen a doctor for this?
_____ ☐ **Vericose Veins** ☐
Past ☐ Present If present, when did it begin? _____ Are they painful?
_____ What aggravates them? _____

Gastro-Intestinal

☐ **Poor/Excessive appetite** ☐ Past ☐ Present When did it begin? _____
Do you feel you have an unhealthy relationship with food? _____
Are you or have you ever been **Anorexic / Bulimic**
Do you feel over-concerned or obsessed with your weight and/or body image? ☐ Yes ☐ No

☐ **Diarrhea** ☐ Past ☐ Present If present, describe symptoms _____
When did it begin? _____What do you think caused or influenced this condition?_____
Is it related to ☐Specific foods ☐Stress ☐Other _____

☐ **Gallbladder problems** ☐ Past ☐ Present If present, describe _____

☐ **Liver problems** ☐ Past ☐ Present If present, describe _____

☐ **Heart burn frequency** ☐ Occasional ☐ Intermittent ☐ Constant

☐ **Excessive thirst** ☐ Past ☐ Present If present, describe _____

☐ **Constipation** ☐ Past ☐ Present If present, describe _____
Is this a lifetime pattern? _____
What do you think caused or influenced this condition? _____
Do you take any medications or natural substances to assist in bowel movements? (please list)
_____
_____

Weight Change

As an adult has your weight range been ☐ High ☐ Low

☐ **Vomiting** ☐ Past ☐ Present If present, when did it begin? _____

☐ **Colitis** ☐ Past ☐ Present If present, when did it begin? _____
What factors affect it? _____

☐ **Gas/bowel after meals** ☐ Past ☐ Present If present, all meals? _____
Certain foods? _____

Female Issues

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period? _____ Your age at first period: _____ Are you still menstruating? ☐ Yes ☐ No Monthly? ☐ Yes ☐ No Menstrual flow: ☐ Scantly ☐ Mild ☐ Moderate ☐ Heavy How many days do you flow? _____ How many days from period to period? _____ Last PAP smear _____
History of abnormal PAP? ☐ Yes ☐ No If yes, what class? _____
Any treatment? _____

Contraception you are currently using _____

Past history of birth control use How long? _____ Side effects _____

Number of pregnancies ___ Live births __ Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure

☐ **Menstrual Cramping** ☐ Mild ☐ Moderate ☐ Severe Do you get cramps every month? _____

If no, how often? _____

☐ **Spotting**

☐ **PMS** ☐ Mild ☐ Moderate ☐ Severe

How many days of symptoms before your period? _____

How many days of symptoms before your period? _____ Circle symptoms:

Breast tenderness / Cry easily / Food cravings / irritability / Bloating weight gain / Suicidal

☐ **Breast lumps/fibrocystic** ☐ Past ☐ Present

☐ **Vaginal infections/yeast** ☐ Past ☐ Present Frequency, how many per year? _____

☐ **DES mother:** Did your mother take DES when pregnant with you? ☐ Yes ☐ No ☐Unknown

☐ **Ovarian, vaginal or uterine problems** ☒ Past ☐ Present

☐ **Infertility** ☐ Past ☐ Present Treatment _____

☐ **Menopause/premenopausal**

Circle symptoms that apply: Hot flashes Vaginal dryness Depression Weight gain irritability Other

_____

☐ **Have your uterus/ovaries been removed?** ☐ Yes ☐ No Reason for Hysterectomy

_____

☐ **Are you on HRT** (hormone replacement therapy)? ☐ Yes ☐ No If yes, what kind? _____

☐ **Sexual dysfunction** ☐ Past ☐ Present If present, describe symptoms:_____

_____

☐ **Painful intercourse** ☐ Past ☐ Present

Male Issues

☐ **Prostate problems:** ☐ Past ☐ Present When did this begin? _____

If present, describe symptoms: _____

List any treatment and its effectiveness: _____

☐ **Incomplete voiding of urine** ☐ Past ☐ Present When did this begin? _____

If present, describe symptoms: _____

List any treatment and its effectiveness: _____

☐ **Pain during urination** ☐ Past ☐ Present When did this begin? _____

If present, describe symptoms: _____

List any treatment and its effectiveness: _____

☐ **Sexual dysfunction** ☐ Past ☐ Present When did this begin? _____

If present, describe symptoms: _____

List any treatment and its effectiveness: _____

Medical history update (update every six months)

Changes:_____
Date: _____ Signature: _____
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Additional comments:

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