Laurel County
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Chiropractic Inc.

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CONFIDENTIAL HEALTH INFORMATION

Today's Date (MM/DD/YYYY) ____________ File # ____________

Whom may we thank for referring you? ____________ Date of Birth ____________

Last Name ____________ First Name ____________ Middle Initial ____________ Nickname ____________

Address ____________ Social Security # ____________ Family Physician ____________

E-Mail Address ____________ Home Phone ____________ Cell Phone ____________

Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name ____________ Phone Number ____________

Child's Name & Age ____________ Child's Name & Age ____________ Child's Name & Age ____________

Your Occupation ____________ Employer's Name & Address ____________ Phone ____________

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare
☐ Auto Accident ☐ Medical Savings Acct & Flex Plan ☐ Other ____________

Name of Primary Insurance Carrier ____________ Policy Number ____________

Name of Secondary Insurance Carrier ____________ Policy Number ____________

Insured Name ____________ Insured Birth Date (MM/DD/YYYY) ____________

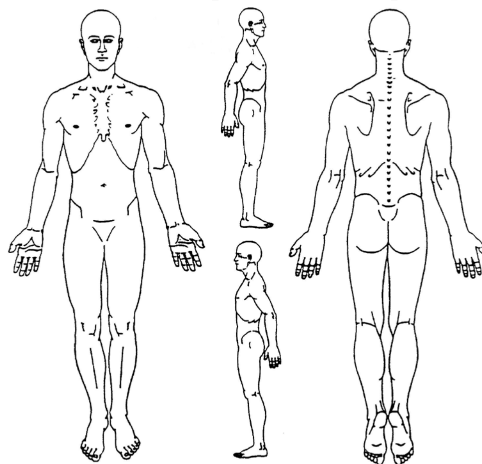
1. The symptom(s) that have prompted me to seek care today include: ______________________________

____

2. Symptoms are the result of (check box):
☐ An accident or injury: ☐ Work ☐ Auto ☐ Other: ______________________________
☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other ______________________________
3. Onset: When did you first notice your current symptoms? ______________________________
4. Describe onset: ☐ Acute ☐ Chronic ☐ Gradual
5. Cause: Unknown ☐ Accident ☐ Other ______________________________
6. Prior Pain: ☐ None ☐ On & Off for years ☐ Other ______________________________
7. Side: ☐ Right ☐ Left ☐ Both (bilateral)
8. Is pain: ☐ Improving ☐ Getting worse ☐ No Change

9. Quality of Symptoms
(What does it feel like)
☐ Achy
☐ Burning
☐ Dull
☐ Sharp
☐ Stiff
☐ Throbbing
☐ Deep
☐ Radiating
☐ Shooting
☐ Numbness
☐ Tingling
☐ Spasms
☐ Nagging
☐ Cramping
☐ Stabbing
☐ Other ______________
____
____
____

10. Location (Where does it hurt?)
Circle the area(s) on the illustration.
'**O**' for current condition
'**X**' for conditions experienced in the past



11. Description of symptoms:
☐ Very Mild ☐ Mild ☐ Mild to Moderate
☐ Moderate ☐ Moderate to Severe ☐ Severe
☐ WNL

12. Intensity
(How extreme are your current symptoms?)
Absent Uncomfortable Agonizing
0 **0-0-0-0-0-0-0-0-0-0** 10

13. Duration (How often does the pain occur?)
☐ Constant (76%-100%)
☐ Frequent (51%-75%)
☐ Intermittent (26%-50%)
☐ Occasional (1%-25%)

14. Radiating to (Does it affect other areas of your body?)
To what areas does the pain radiate, shoot or travel?) ______________________________

____

15. Prior Interventions (What have you done to relieve the symptoms?)
☐ Prescription medications ☐ Surgery ☐ Over-the-counter drugs ☐ Acupuncture ☐ Chiropractic
☐ Homeopathic remedies ☐ Heat ☐ Ice ☐ Physical therapy ☐ Massage
☐ Other ______________________________

16. Aggravation or relieving factors (What makes it better or worse; such as time of day, movements, certain activities, etc.):
What tends to worsen the problem? ______________________________
What tends to lessen the problem? ______________________________

17. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐	Grocery shopping	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	Showering or bathing	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Love Life	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐	Getting to sleep	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	Staying asleep	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	Concentrating	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐	Yard work	☐	☐	☐	☐

____
Patient's Initials

____
Doctor's Initials

18. How much sleep do you average per night? ____ Hours

19. How does your current condition **INTERFERE** with your:
Work or career: ______________________________
Recreational activities: ______________________________
Household responsibilities: ______________________________
Personal relationships: ______________________________

20. Social History (Tell Laurel County Chiropractic about your health habits and stress levels.)

Alcohol use	☐ Daily ☐ Monthly	How Much ________	Coffee use	☐ Daily ☐ Monthly	How Much ________
Tobacco use	☐ Daily ☐ Monthly	How Much ________	Exercising	☐ Daily ☐ Monthly	How Much ________
Pain Relievers	☐ Daily ☐ Monthly	How Much ________	Soft Drinks	☐ Daily ☐ Monthly	How Much ________
Water Intake	☐ Daily ☐ Monthly	How Much ________			

21. In addition to the main reason for your visit today, what additional health goals do you have? ______________________________
____

22. How do your symptoms affect your ability to perform daily activities?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No complaints — Mild, forgotten with activity — Moderate, interferes with activity — Limiting, prevents full activity — Intense, preoccupied with seeking relief — Severe, no activity possible

23. Review of systems

a. Musculoskeletal System

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck Pain	☐	☐	Back Problems	☐	☐	Hip Disorders	None ☐ Initials ____
☐	☐	Knee Injuries	☐	☐	Foot/Ankle Pain	☐	☐	Shoulder Problems	☐	☐	Elbow/Wrist Pain	☐	☐	TMJ Issues	☐	☐	Poor Posture	

b. Neurological System

☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & Needles	☐	☐	Numbness	None ☐ Initials ____

c. Cardiovascular System

☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	High Cholesterol	☐	☐	Poor Circulation	☐	☐	Angina	☐	☐	Excessive Bruising	None ☐ Initials ____

d. Respiratory System

☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay Fever	☐	☐	Shortness of Breath	☐	☐	Pneumonia	None ☐ Initials ____

e. Digestive System

☐	☐	Anorexia /Bulimia	☐	☐	Ulcer	☐	☐	Food Sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea	None ☐ Initials ____

f. Sensory System

☐	☐	Blurred Vision	☐	☐	Ringing in Ears	☐	☐	Hearing Loss	☐	☐	Chronic Ear Infection	☐	☐	Loss of Smell	☐	☐	Loss of Taste	None ☐ Initials ____

g. Integumentary System

☐	☐	Skin Cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair Loss	☐	☐	Rash	None ☐ Initials ____

h. Endocrine System

☐	☐	Thyroid	☐	☐	Immune Disorders	☐	☐	Hypoglycemia	☐	☐	Frequent Infection	☐	☐	Swollen Glands	☐	☐	Low Energy	None ☐ Initials ____

i. Genitourinary System

☐	☐	Kidney Stones	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate Issue	☐	☐	Erectile Dysfunction	☐	☐	PMS Symptoms	None ☐ Initials ____

j. Constitutional System

☐	☐	Fainting	☐	☐	Low Libido	☐	☐	Poor Appetite	☐	☐	Sudden Weight Gain/Loss (circle one)	☐	☐	Fatigue	☐	☐	Weakness	None ☐ Initials ____

Patient's Initials ______

Doctor's Initials ______

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illness and treatments. Please complete each section fully.

24. Illnesses

Check the illnesses you have had in the past and have now.

Had	Have	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	HIV Positive
☐	☐	Malaria
☐	☐	Measles
☐	☐	Multiple Sclerosis
☐	☐	Mumps
☐	☐	Polio
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sexually Transmitted Disease
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Typhoid Fever
☐	☐	Ulcer
☐	☐	Other ______________________________

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25. Operations

Surgical intervention which may or may not have included hospitalization.

- ☐ Appendix Removal
- ☐ Bypass Surgery
- ☐ Cancer
- ☐ Cosmetic Surgery
- ☐ Elective Surgery ____________________

____

- ☐ Eye Surgery
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Spine ____________________________

____

- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other ____________________________

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26. Treatments

Check the ones you've received in the past or are currently receiving.

Had	Have	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Blood Transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic Care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone Replacement
☐	☐	Inhaler
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Nutritional Supplements List ____________________________

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Had	Have	
☐	☐	Medications (Prescription and Over-the Counter) List ____________________________

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27. Injuries Have you ever…

- ☐ Had a fractured or broken bone
- ☐ Used a crutch or other support
- ☐ Had a spine or nerve disorder
- ☐ Used neck or back bracing
- ☐ Been knocked unconscious
- ☐ Received a tattoo
- ☐ Been injured in an accident
- ☐ Had a body piecing

Family History Some health issues are hereditary. Tell Laurel County Chiropractic about the health of your immediate family members.

Relative	Age (if living)	Sate of Health: Good	Poor	Illness	Age at Death	Cause of Death: Natural	Illness
Mother	____________	☐	☐	____________	____________	☐	☐
Father	____________	☐	☐	____________	____________	☐	☐
Sister 1	____________	☐	☐	____________	____________	☐	☐
Sister 2	____________	☐	☐	____________	____________	☐	☐
Brother 1	____________	☐	☐	____________	____________	☐	☐
Brother 2	____________	☐	☐	____________	____________	☐	☐

If the patient is a minor, print child's full name: ____

____ Signature

____________________________ Date (MM/DD/YYYY)

__________ Patient's Initials

__________ Doctor's Initials