Cater Chiropractic Clinic

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes **When?**

Whom may we thank for referring you?

Gender

Male Female

If so, whom?

Your Last Name

Your Social Security Number

Your First Name **Your Middle Name (or Initial)**

Birth Date (MM/DD/YYYY)

Marital Status

Single Married Divorced

Widowed Separated

Address

City **State/Province** **ZIP/Postal Code**

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes No

Address

City **State/Province** **ZIP/Postal Code**

Work Phone

Insurance Carrier **Policy Number**

Primary Care Provider's Name

Insured's Last Name

Who carries this policy?

Self Spouse Parent

First Name **Your Middle Name (or Initial)**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

CATER CHIROPRACTIC CLINIC

Patient Name

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

2. And are the result of (darken circle): An accident or injury

Work Auto Other ______________________

A worsening long-term problem

An interest Wellness Other ______________________

3. Onset (When did you first notice your current symptoms?)

4. Intensity (How extreme are your current symptoms?)

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?) Constant

Comes and goes How often? ____________

6. Quality of symptoms

(What does it feel like?)

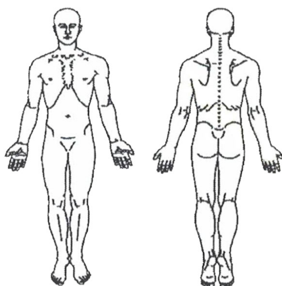
- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other ______________________

7. Location (Where does it hurt?)

Circle the area(s) on the illustration.

"O" for current condition

"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating 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?

10. Prior Interventions

Prescription medication	Ice
Over-the-counter drugs	Heat
Homeopathis remedies	Chiropractic
Physical Therapy	Massage
Surgery	Acupunture
Other ____________	

11. What else should Dr. Cater know about your condition?

____

12. How does your current conditions interfere with your:

Work or Career: ______________________

Household responsibilites: ______________________

Recreational abilities: ______________________

Personal relationships: ______________________

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any conditions that you've HAD or currently HAVE and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ____

Patient Name

CATER CHIROPRACTIC CLINIC

(Contiued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight change	○	○	Weakness	NONE ○ Initials ____

Past Personal, Family and Social History

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

14. Illnesses

Check the illnesses you have **HAD** in the past or **HAVE** now.

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

15. Operations

Surgical interventions, which may of may not have included hospitalization.

- Appendix removal
- Bypass surgery
- Cancer
- Cosmetic Surgery
- Elective Surgery ____
- ____
- Eye Surgery
- Hysterectomy
- Pacemaker
- Spine ____
- ____
- Tonsillectomy
- Vasectomy
- Other: ____
- ____
- ____
- ____

16. Treatments

Check the ones you've received in the **PAST** or **CURRENTLY**

Past	Currently	
		Acupuncture
		Antibiotics
		Birth control pills
		Blood transfusions
		Chemotherapy
		Chiropractic Care
		Dialysis
		Herbs
		Homeopathy
		Hormone replacement
		Inhaler
		Massage therapy
		Physical therapy
		Nutritional supplements

List: ____

____

Medications:

List: ____

____

17. Injuries

Have you ever...

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

18. Family History

Some health issues are hereditary. Tell Dr. Cater about the health of your immediate family members.

Relative	Age (If living)	State of health: Good	State of health: Poor	Illness	Age of death	Cause of death: Natural	Cause of death: Illness
Mother	____			____	____		
Father	____			____	____		
Sister 1	____			____	____		
Sister 2	____			____	____		
Brother 1	____			____	____		
Brother 2	____			____	____		
____	____			____	____		

19. Are there any other hereditary health issues that you know about? ____

____

Doctor's Initials

20. Social History
Tell Dr. Cater about your health habits and stress levels.

Alcohol use	Daily	Weekly	How much? ______	Prayer or meditation?	Yes	No
Coffee use	Daily	Weekly	How much? ______	Job pressure/stress?	Yes	No
Tobacco use	Daily	Weekly	How much? ______	Financial peace?	Yes	No
Exercising	Daily	Weekly	How much? ______	Vaccinated?	Yes	No
Pain relievers	Daily	Weekly	How much? ______	Mercury fillings?	Yes	No
Soft Drinks	Daily	Weekly	How much? ______	Recreational drugs?	Yes	No
Water intake	Daily	Weekly	How much? ______			
Hobbies:						

Patient Name

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

	No Affect	Mild Affect	Moderate Effect	Severe Effect
Sitting				
Rising out of chair				
Standing				
Walking				
Lying down				
Bending over				
Climbing stairs				
Using a computer				
Getting in/out of car				
Driving a car				
Looking over shoulder				
Caring for family				

	No Affect	Mild Affect	Moderate Effect	Severe Effect
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Love life				
Getting to sleep				
Staying asleep				
Concentrating				
Exercising				
Yard work				

22. What is the major stressor in your life? ______
23. How much sleep do you average per night? ______
24. What is the type and approximate age of your mattress and pillow? ______
25. What is your preferred sleeping position? ______
26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking
27. What would be the most significant thing that you could do to improve your health? ______

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

______

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can be best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or orrect vertebral sublaxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): ______

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concerns.

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

Doctor's Initials

______ ______
Signature Date (MM/DD/YYYY)