Carraway Chiropractic Center UPDATED PATIENT HISTORY

Your Name_____ **Today's Date**_____

If you have new contact or insurance information, please let the front desk know.

Your e-mail: _____ *(By providing my email address, I authorize my doctor to contact me via my email address.)* **For security verification, in what city were you born?:** _____

Please describe your condition: _____

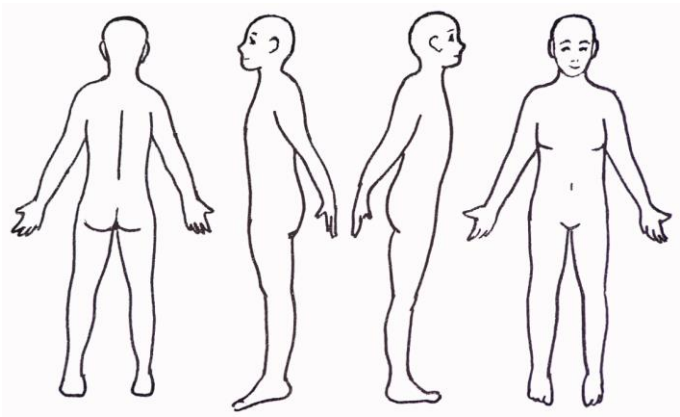
_____

When did this problem start? Month_____ Day_____ Year_____

How did this problem begin? (Accident/injury/fall, etc.)_____

_____

By using the key below, please mark on the body diagrams where you are experiencing the following symptoms:



= Numbness and tingling

X = Burning

/ = Stabbing

O = Pins and Needles

\+ = Dull Ache

What percentage of the day do you experience your symptoms?

❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%

What describes the nature of your symptoms? (Choose any that apply)

❒ Sharp ❒ Dull Ache ❒ Numb ❒ Shooting ❒ Cramping
❒ Burning ❒ Stabbing ❒ Tingling ❒ Throbbing ❒ Deep

Other:_____

How are your symptoms changing? ❒ Getting better ❒ Not changing ❒ Getting worse

Please indicate the intensity of your symptoms: (0 = No pain, 10 = Unbearable pain)

No Pain ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ **Unbearable Pain**
0 1 2 3 4 5 6 7 8 9 10

Are your symptoms worse ❒ in the morning ❒ by midday ❒ throughout the day ❒ at the end of the day ❒ during the night

Does anything relieve your symptoms? ❒ sitting ❒ standing ❒ lying down ❒ medication ❒ rest
❒ ice ❒ heat ❒ stretching ❒ movement ❒ no movement

Other:_____

Who have you seen for your symptoms? ❒No one ❒Other chiropractor ❒Medical Doctor ❒Physical Therapist

Name of medical doctor, other chiropractor or therapist: _____

What treatment did you receive for your symptoms?
❒Adjustments ❒Physical Therapy ❒Medication ❒Surgery ❒Other: _____

When did you receive this treatment?
❒In the last month ❒2-3 months ago ❒3-6 months ago ❒6 months to 1 year ago
❒1-2 years ago ❒2-5 years ago ❒5-10 years ago

What tests have you had for your symptoms? ❒X-rays ❒MRI ❒CT Scan ❒Other_____

When were these tests done?
❒In the last month ❒2-3 months ago ❒3-6 months ago ❒6 months to 1 year ago
❒1-2 years ago ❒2-5 years ago ❒5-10 years ago

Have you had similar symptoms in the past? ❒Yes ❒No

If you have been seen for treatment in the past for same or similar symptoms, who did you see?
❒This office ❒Other chiropractor ❒Medical Doctor ❒Physical Therapist
❒Other Name of chiropractor, medical doctor or therapist: _____

REVIEW OF SYSTEMS *Do you have or have you ever had any of the following?* ***Please circle your condition or write it in, and check whether it is Present or Past.***

	Present	*Past*	*Never*
1. Musculoskeletal system – Such as osteoporosis, arthritis, neck pain, back problems, broken bones Other: _____	❍	❍	❍
2. Neurological system – Such as headache, dizziness, numbness, pinched nerve, seizures Other: _____	❍	❍	❍
3. Cardiovascular system – Such as high blood pressure, heart attack, high cholesterol, stroke, **pacemaker** Other: _____	❍	❍	❍
4. Respiratory system – Such as asthma, apnea, emphysema, shortness of breath, pneumonia, frequent colds Other: _____	❍	❍	❍
5. Digestive system – Such as ulcer, food sensitivities, heartburn, constipation, diarrhea, anorexia/bulimia Other: _____	❍	❍	❍
6. Eyes – Such as blurred vision, glaucoma, macular degeneration, cataracts Other: _____	❍	❍	❍
7. Ears, Nose, Throat – Such as hearing loss, ringing in the ears, nose bleeds, sinusitis, frequent sore throat Other: _____	❍	❍	❍
8. Skin – Such as shingles, skin cancer, psoriasis, eczema, acne, hair loss, rash Other: _____	❍	❍	❍
9. Endocrine system – Such as diabetes (Type I or II?), thyroid issues, frequent infection Other: _____	❍	❍	❍
10. Genitourinary system – Such as kidney stones, infertility, prostate issues, PMS symptoms Other: _____	❍	❍	❍
11. Constitutional system – Such as fainting, poor appetite, fatigue, sudden weight change, weakness Other: _____	❍	❍	❍
12. Hematologic/Lymphatic – Such as cancer, fever/chills/sweats, easy bruising, bleeding, blood clots Other: _____	❍	❍	❍
13. Mental Health – Such as depression, anxiety, insomnia, mental illness Other: _____	❍	❍	❍
14. Allergic/Immunologic – Such as food allergies, seasonal allergy, HIV Aids, Lupus Other: _____	❍	❍	❍

Surgeries, health problems, injuries or treatments since your most recent evaluation with us: _____

_____

_____

Please list your current medications, including prescription, over-the-counter, vitamins and supplements: *(If you have a list with you, please give it to the receptionist to copy for your records)*_____

_____

_____

Do you have any allergies (medications, food, environmental)? ❒Yes ❒No Please list :_____

_____

Social History

Tobacco History: ❑ Never smoked ❑Former Smoker ❑Current smoker How often do you smoke? __Every day __Sometimes

If you smoke, what is your level of interest in quitting smoking? ❑0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Interest ***Very Interested***

Do you drink caffeinated coffee, tea or soda? How much/ often_____

Do you drink alcohol (beer, wine, liquor)? ___ Never ___Rarely ___Occasionally ___Frequently What type? _____

Do you use illegal / recreational drugs? ___ Never ___Rarely ___Occasionally ___Frequently What type? _____

Do you get adequate sleep? __ Never __Rarely __Sometimes __Most of the time __ Always

Do you exercise? ___Not at all ___Occasionally ___Regularly What type(s) of exercise? _____

Recreational activities: __Walking __Golf __Running __Tennis __Swimming __Boating Other: _____

How often do you use pain relieving drugs, either over-the-counter or prescription? ___ Never ___Rarely ___Occasionally ___Frequently

What is your "healthy eating" level? __Very healthy __Somewhat healthy __Not very healthy __Unhealthy

Are you experiencing unusual stress? __Yes ___No Major stressor: _____

Family History: Check if any blood relatives have had: ❒Heart Disease ❒High Blood Pressure ❒Stroke ❒Diabetes ❒Cancer
Relationship: _____

What is your occupation? _____

What is your work status? ❒Full time ❒Part time ❒Self employed ❒Unemployed ❒Retired

Are you? ❒Married ❒Single ❒Widowed ❒Divorced ❒Legally separated

VITALS: Your height: ____ ft. ____inches **Your weight:** _____lbs **Are you:** ❒Right handed ❒Left handed

Who is your primary care physician? _____ Location: _____

FEMALE PATIENTS: To your knowledge, are you pregnant? ❒No ❒Yes Date of last period _____

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT

How will you pay for today's visit? ❒Cash ❒Check ❒Debit Card ❒VISA ❒MasterCard ❒Discover ❒Amex

Are you insured? ❒Yes ❒No Insured's name, if other than yourself: _____

Insured's date of birth: _____ Relationship: _____ Insured's Employer: _____

PLEASE GIVE YOUR DRIVERS LICENSE AND INSURANCE CARD(S) TO THE RECEPTIONIST SO WE MAY COPY THEM FOR YOUR RECORDS

I hereby authorize my insurance benefits be paid directly to Christopher A. Carraway, D.C., realizing I am responsible to pay for any co-insurance, co-payments, deductibles and non-covered services, and I authorize the use of this signature on all insurance submissions. Notwithstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all remaining charges. I hereby grant permission to Dr. Carraway and his staff to perform any necessary services needed for the diagnosis and treatment of my condition. I hereby authorize the release of any and all necessary protected health information to insurance carriers, attorneys, employers, and other healthcare providers, or any other necessary parties for the purpose of treatment, payment, and healthcare operations. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature: _____Date_____

Parent or Guardian's Signature Authorizing Care for Minor Child:

_____Date_____