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.

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:

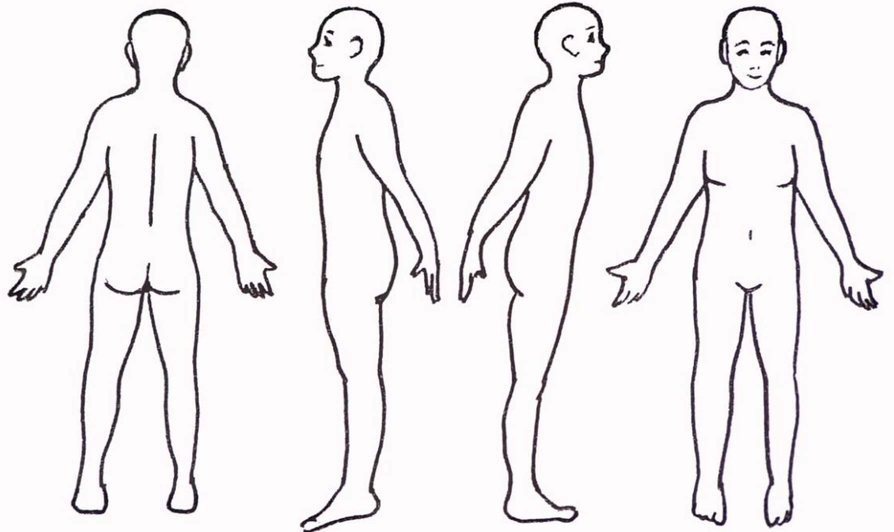
= Numbness and tingling

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: ____

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__________________