Chait Chiropractic Center **Patient Health History**

How did you hear about our office? ______________________ **Referred By:** ____________

Today's Date [/ /] **Signature of Patient** ______________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name ______________________ **Nick Name** ______________________

Last Name ______________________ **Middle Name** ______________ **Suffix** ________

Address 1 ____

Address 2 ____

City ______________________ **State** ________ **Zip Code** ____________

Home Phone ______________________ **Mobile Phone** ______________________

Home email ______________________

Contact Method *(check one)*

❑ Home Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** ______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ______________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other ________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: ______________________
Answers must be at least 6 characters.

Payment Method: Cash ❑ Credit Card ❑ Private Insurance ❑ Medicare ❑ Medicaid ❑

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

If yes, 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 currently drink alcoholic beverage of any kind? ☐ Yes ☐ Former drinker ☐ Never been a drinker

If yes, how often do you drink: ☐ Current every day drinker ☐ Current sometimes drinker

If yes, what is your level of interest in quitting drinking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ☐

	Start Date		Start Date
1)		5)	
2)		6)	
3)		7)	
4)		8)	

List any known allergies you have had to any medications. If no allergies are known, check here: ☐

1) ____________ 3) ____________

2) ____________ 4) ____________

Current vitamins, including frequency and dosage if known. ____________

____

Briefly list your main health problems: ____________

____

Has any doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No

If yes, describe: ____________

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure

If yes, other comments regarding Diabetes: ____________

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ☐ Yes ☐ No

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History of Complaint

Please identify the condition(s) that brought you to this office:

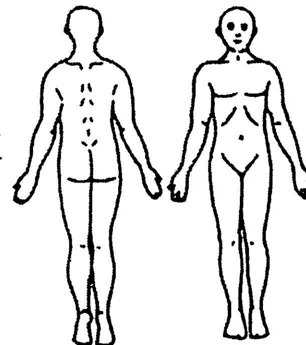
Primarily: ______________________ Secondarily: ______________________
Third: ______________________ Fourth: ______________________

Instructions: Please circle the number that best describes the questions being asked.
What is your pain right now? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What is your typical pain? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What is your pain at its best? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What is your pain at its worst? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When and how did the problem(s) begin? ______________________
When is the problem at its worst? AM PM mid-day late PM
What is the frequency of discomfort? Continuous Intermittent Occasional Frequent
Was the condition treated by anyone in the past? Yes ❑ No ❑
If yes by whom?__________ What were the results?__________
Have you ever seen a chiropractor? Yes ❑ No ❑

***PLEASE MARK** the areas on the
diagram with the following **letters** to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching, **DP = Deep, C = Cramping, SF = Stiffness**
N = Numbness **S** = Sharp, **ST = Stabbing, T= Tingling, TH = Throbbing**

My condition is a result of:
[ ] Prolonged Position [ ] Prolonged Activity
[ ] Over exertion [ ] Awkward Motion
[ ] A worsening long-term problem
[ ] An accident or injury: [ ] Work [ ] Auto
[ ] Other:______________________
What makes it feel worse? ______________________
What makes it feel better? ______________________



Activities of Daily Life: Please identify how your current condition is affecting your ability
to carry out activities that are routinely part of your life:

Lifting Objects ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Sit to Stand ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Climbing Stairs ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Concentration ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Household Chores ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Grooming ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Bending Over ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Sleep ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Sitting ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Standing ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Walking ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform

What are you goals for care in our office?
[ ] I just want relief of my immediate pain
[ ] I would like to address the underlying problem.
[ ] I am interested in being the healthiest I can be and learning how to stay that way.
[ ] Other: ______________________

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Review of Systems

Please check any of the following you may have had or have

Musculoskeletal
[ ] Osteoporosis [ ] Arthritis [ ] Scoliosis [ ] Neck pain [ ] Back pain
[ ] Hip disorders [ ] Knee problems [ ] Foot/ankle [ ] Shoulder issues [ ] Elbow/wrist issues
[ ] TMJ issues [ ] Poor posture

Neurological
[ ] Anxiety [ ] Depression [ ] Dizziness [ ] Pins & needles [ ] Numbness

Cardiovascular
[ ] High blood pressure [ ] Low blood pressure [ ] High cholesterol
[ ] Poor circulation [ ] Excessive bruising [ ] Angina

Respiratory
[ ] Asthma [ ] Sleep apnea [ ] Emphysema [ ] Hay fever
[ ] Pneumonia [ ] Shortness of breath

Digestive
[ ] Anorexia [ ] Bulimia [ ] Food sensitivities [ ] Heartburn
[ ] Constipation [ ] Diarrhea

Sensory
[ ] Blurred vision [ ] Ears ringing [ ] Hearing loss [ ] Chronic ear infection
[ ] Loss of smell [ ] Loss of taste

Integumentary
[ ] Skin cancer [ ] Psoriasis [ ] Eczema [ ] Acne
[ ] Rash [ ] Hair loss

Endocrine
[ ] Thyroid issues [ ] Immune disorders [ ] Hypoglycemia [ ] Frequent infection
[ ] Swollen glands [ ] Low energy

Genitourinary
[ ] Kidney stones [ ] Infertility [ ] Frequent urination [ ] Prostate issues
[ ] Erectile dysfunction [ ] PMS symptoms

Constitutional
[ ] Fainting [ ] Low libido [ ] Poor appetite [ ] Fatigue [ ] Weakness
[ ] Sudden weight loss or gain (circle one)

Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sisters brothers sons daughters
What type of condition:
____

Any other hereditary conditions the doctor should be aware of? No Yes:
____

Have you ever seen a chiropractor before? Yes No
If yes, Whom? ____
What was your experience? ____

What position do you sleep in? [ ] side [ ] back [ ] stomach [ ] sitting
Is there anything else you'd like the doctor to be aware of?______________________
____

Are you wearing Heel Lifts ( ) Arch Supports ( )

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Please list any major injuries, illnesses, surgeries and treatments you may have had or have.

Illness
[ ] AIDS
[ ] Alcoholism
[ ] Allergies
[ ] Arteriosclerosis
[ ] Cancer
[ ] Chicken pox
[ ] Diabetes
[ ] Epilepsy
[ ] Glaucoma
[ ] Gout
[ ] Heart disease
[ ] Hepatitis
[ ] HIV Positive
[ ] Malaria
[ ] Measles
[ ] Multiple Sclerosis
[ ] Mumps
[ ] Polio
[ ] Rheumatic fever
[ ] Scarlet fever
[ ] Sexually transmitted disease
[ ] Stroke
[ ] Tuberculosis
[ ] Typhoid fever
[ ] Ulcers

Operations
[ ] Appendix
[ ] Bypass surgery
[ ] Cancer
[ ] Eye surgery
[ ] Hysterectomy
[ ] Pacemaker
[ ] Spine: ___________
[ ] Tonsillectomy
[ ] Vasectomy
[ ] Physical therapy
[ ] Hernia repair
[ ] Other: ___________
____

Treatments
[ ] Acupuncture
[ ] Antibiotics
[ ] Chemotherapy
[ ] Chiropractic care
[ ] Dialysis
[ ] Herbs
[ ] Hormone replacement
[ ] Inhaler
[ ] Massage

Injuries
[ ] Broken bone
[ ] Car accident
[ ] Knocked unconscious
[ ] Spine disorder
[ ] Nerve disorder
[ ] Hernia

Acknowledgements

Initials ____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can 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 correct vertebral subluxation. Chiropractic is a separate and distinct healing are from medicine and does not proclaim to cure any named disease or entity.

Initials ____ 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 for any involved third parties.

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

Initials ____ I hereby authorize payment to be made directly to John R. Chait, Inc. for all benefits which may be payable under a healthcare plan or from any other collateral sources.

Initials ____ 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 concern.

______________________________ ______________________________
Patient or Authorized Person's Signature **Date Completed**

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