Van Drisse Chiropractic Center
Patient Information Form

NAME (Last, First, MI) _____

HOME ADDRESS _____
(City) (State) (Zip)

HOME PHONE_____CELL PHONE_____EMAIL _____

SS#_____-_____-_____ MARITAL STATUS: S / M / D/ W SEX: M / F DATE OF BIRTH_____/_____/_____

NAME OF SPOUSE _____ DATE OF BIRTH _____/_____/_____

PATIENT'S EMPLOYER_____PHONE:_____

*EMERGENCY CONTACT_____ PHONE: _____

*RELATIONSHIP TO PATIENT _____

Whom may we thank for referring you? _____

ACCIDENT INFORMATION

Is this due to an accident? _____ YES _____ NO DATE _____
Type of accident ____ Auto _____ Work _____ Home _____Other
To who have you made a report of your accident?
_____ Auto Insurance _____ Employer _____ Work Comp _____ Other
Attorney Name (if applicable) _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company(s) assign directly to
Van Drisse Chiropractic Center L.L.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative **Print name** of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient (For Guardian, or Personal Representative)

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Health History Form

Name: _____

HABITS:

Do you smoke or chew tobacco? ☐ Yes ☐ No

How much coffee/tea do you typically consume a day? ☐ none ☐ 1 to 2 cups ☐ 3 to 7 cups ☐ 8 or more cups

How much soda/pop do you typically consume a day? ☐ none ☐ 1 to 2 cups ☐ 3 to 7 cups ☐ 8 or more cups

How much alcohol do you typically consume a week? ☐ none ☐ 1 to 2 drinks ☐ 3 to 7 drinks ☐ 8 or more drinks

Typical physical activity at work? ☐ mostly sitting ☐ light manual labor ☐ manual labor ☐ heavy manual labor

General physical activity when not working? ☐ mostly sitting/relaxing ☐ usually active ☐ usually very active

Outside of work, do you exercise on a regular basis? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

How is your father's health? ☐ good ☐ fair ☐ poor ☐ deceased

How is your mother's health? ☐ good ☐ fair ☐ poor ☐ deceased

How is your siblings'' health ☐ good ☐ fair ☐ poor ☐ deceased

List any health problems that run in your family. _____

Has anyone in your immediate family ever had a stroke? ☐ Yes ☐ No

FEMALE'S ONLY

Date of last OB/GYN exam: _____

Were the results of your last OB/GYN exam/pap smear normal? ☐ Yes ☐ No ☐ Unsure

Age of each of your children: _____, _____, _____, _____, _____, _____

Underline each symptom/problem you have had in the last year:

painful periods	excessive flow during period	PMS	yeast infection
hot flashes	cramps or backache during cycle	vaginal discharge	miscarriage

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Is there a chance that you might be pregnant? ☐ Yes ☐ No

When did your last menstrual period begin? _____

Do you have irregular cycles? ☐ Yes ☐ No ☐ Unsure

Are you taking oral contraceptives? ☐ Yes ☐ No ☐ Unsure

Do you have an IUD? ☐ Yes ☐ No ☐ Unsure

PREGNANCY WARNING AND CONSENT TO X-RAY

Signature only needed if female

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that if there is a chance that I might be pregnant the 10 days following onset of a menstrual period are generally considered to be the safest time for an x-ray examination.

With full understanding of the above, and believing that I am not currently at risk, I give the doctors of Van Drisse Chiropractic permission to perform an x-ray examination on me if they feel it is necessary.

Patient's Signature _____ Date _____

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Health History Form

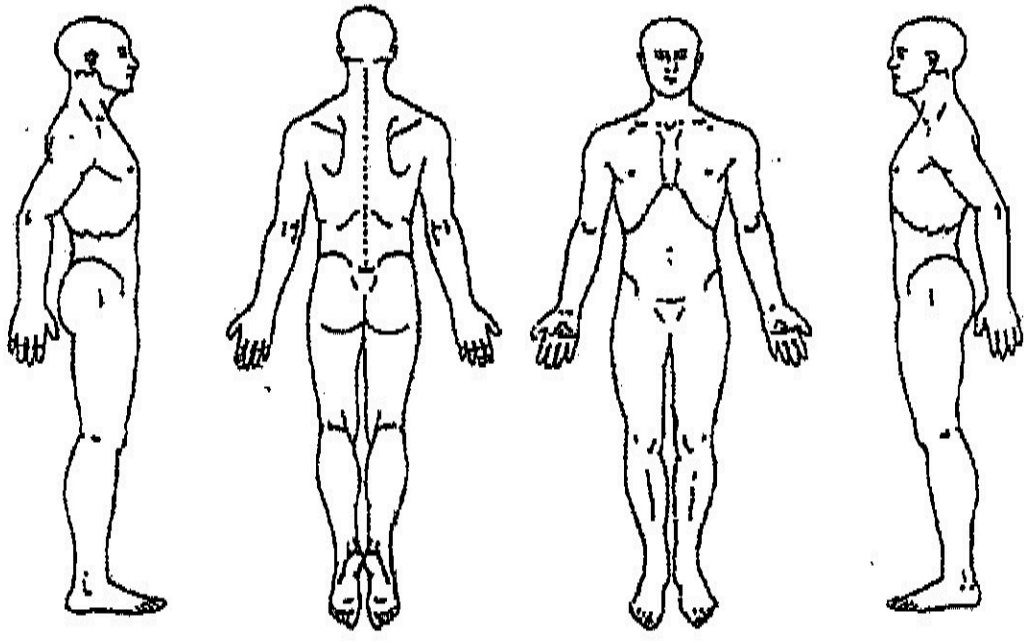
Name: _____

Describe the health problems that you are here for. Be as specific as possible. _____

_____

MARK ON THE PICTURE WHERE YOU HAVE SYMPTOMS. PLEASE USE THE FOLLOWING SYMBOLS:

Stiffness
S S S S S S S S S
S S S S S S S S S
Dull/Aching
O O O O O O O O O
O O O O O O O O O
Stabbing Pain
/ / / / / / / / / / /
/ / / / / / / / / / /
Burning
X X X X X X X X X X
X X X X X X X X X X
Numbness
- - - - - - - - - - -
- - - - - - - - - - -
Pins & Needles
+ + + + + + + + + +
+ + + + + + + + + +



On a scale of 0-10, with 0 meaning NO symptoms/can function normally, and 10 meaning very severe symptoms/cannot function at all, where would you rate yourself overall. (Place an "X" on the line.)

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10_____

NO SYMPTOMS VERY SEVERE SYMPTOMS

Have you ever seen a medical doctor, doctor of chiropractic, or physical therapist for this problem? ☐Yes ☐No

Do you have ANY other health problems or symptoms that have not yet been covered today? ☐Yes ☐No

What? _____

My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.

Patient's Signature _____ **Date** _____

NOTES: _____

_____

_____

_____

_____

CC: chief complaint O: onset S: severity F: freq. R: radiation Pr: proactive Pa: palliative Hx: prior history/intervention G: tx goals/ADL

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Name: _____

Primary Care Physician (PCP): _____

Date of last appointment with PCP: _____

Have you ever had surgery? If so, what was the procedure(s)? _____	☐ Yes	☐ No
Have you ever been diagnosed with a long-term or ongoing health problem?	☐ Yes	☐ No
Have you ever been diagnosed with cancer?	☐ Yes	☐ No
Have you been sick at all in the last 60 days?	☐ Yes	☐ No
Have you ever had a convulsion, seizure or stroke of any kind?	☐ Yes	☐ No
Have you ever passed out, blacked out or fainted?	☐ Yes	☐ No
Have you been dizzy or lightheaded in the last 60 days?	☐ Yes	☐ No
Do you have any unusual vision or hearing problems recently?	☐ Yes	☐ No
Have you had ringing in your ears in the last 60 days?	☐ Yes	☐ No
Have you had a headache in the last 60 days?	☐ Yes	☐ No
Have you ever had a heart attack or been diagnosed with a heart condition?	☐ Yes	☐ No
Have you ever been diagnosed with high or low blood pressure?	☐ Yes	☐ No
Do you have frequent colds, sinus infections, ear infections or sore throats? (Circle all that apply)	☐ Yes	☐ No
Do you have asthma or any allergies? Please list here _____	☐ Yes	☐ No
Males, have you ever been diagnosed with a prostate problem?	☐ Yes	☐ No
Do you have trouble controlling urination?	☐ Yes	☐ No
Have you had frequent or painful urination in the last 60 days?	☐ Yes	☐ No
Have you had a kidney or bladder infection in the last 60 days?	☐ Yes	☐ No
Do you have a problem with re-occurring kidney/bladder infections?	☐ Yes	☐ No
Have you been constipated or had diarrhea in the last 60 days?	☐ Yes	☐ No
Do you have any sores or skin lesions that aren't healing?	☐ Yes	☐ No
Have you had weakness, twitching or tremors in your arms/hands or legs/feet in the last 60 days?	☐ Yes	☐ No
Have you ever broken a bone or dislocated a joint?	☐ Yes	☐ No
Have you ever had a motor vehicle accident or fender bender?	☐ Yes	☐ No
Have you ever had a fall or injury that required professional attention?	☐ Yes	☐ No
Have you ever been given a permanent disability rating?	☐ Yes	☐ No
Have you ever had a spinal x-ray, MRI, or CAT scan?	☐ Yes	☐ No
Have you ever had chiropractic care before?	☐ Yes	☐ No

*If you marked **YES** to any questions that require further explanation, please do so below:

_____

_____

_____

_____

_____