Woodruff Chiropractic Medicine – Confidential Patient Information

Name _____ Date _____

Address _____ City/State/Zip _____

Home phone_____ Work phone _____

Cell Phone _____ Age_____ Birth Date_____

SSN# _____ Marital: M S W D How many children?_____

Name of Spouse _____ Spouse's Birth Date _____

Occupation _____

Employer_____

Who referred you to us? _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of an auto or other type of accident? _____

Number of days lost from work _____ Date symptoms appeared or accident happened _____

Briefly describe the reason for your visit here:

_____

_____

In the past have you ever had the same or a similar condition? ___yes ___no If yes, please describe:

_____

Please list all doctors you have seen related to you current concern, also please include any chiropractors or family medical doctors. If possible list the approximate date of the last visit and their city and telephone number.

1.
_____

2.
_____

3.
_____

Please describe any special tests (X-ray, MRI, EKG, blood work, etc.) to investigate your current concern.

_____

Please list any medications you have taken in the past year.

1. _____, 2. _____, 3. _____,

4._____, 5_____, 6_____

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I, the undersigned, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submission whether manual or electronic. I consent to proceed with the interview and examination. I understand that any treatment will be explained to me and my verbal consent will be requested before any care is rendered.

Signature_____ Date _____

PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing?

_____

_____

2. If this is a reoccurrence, when did you originally notice the problem? _____

What initially caused it? _____

3. Has it changed recently? ___Better ___Worse ___Same What types of treatment have you tried?

_____

What makes it better? _____ Worse? _____

4. How frequent is the condition? _____How long does it last? _____

5. Is this affecting your sleep? ___Yes ___No If yes, please describe:_____

6. Is this affecting your ability to perform your job or daily activities? ___Yes ___ No If yes, please describe:

_____

7. Are there any other symptoms that may be related to these concerns, which you have not listed? ___Yes ___No

If yes, please describe:

_____

Survey of Your Health History

Please circle all that apply. Indicate whether this is a current or old concern by providing an approximate date.

1. **General**

Fever
Night sweats
Nervous ness
Bleeding
Diabetes
Thyroid
Headache
Fainting
Depression
Memory loss
Chills
Fatigue

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Weight loss/gain
Anemia
Cancer
Substance abuse
Dizziness
Seizures
Phobias
Waking in night
Problems falling asleep
Explain any surgeries or hospitalizations: _____
Any broken bones, car accidents or
other injuries? _____

2. **Gastrointestinal**
belching/gas
vomiting
bloody stools
hernia
constipation
diarrhea
abdominal pain
nausea
liver problems
other_____

3. **Respiratory**
breathing problems
spitting phlegm/blood
allergies
asthma
shortness of breath
chronic cough
pneumonia
other _____

4. **Cardiovascular**
irregular heartbeat
racing heart
chest pain
high blood pressure
swelling
prior heart problem
pacemaker
stroke
other _____

5. **Musculoskeletal**
stiffness
pain
swelling
spinal curve
arthritis
weakness
twitching
tremors
numbness
other _____