CONFIDENTIAL
HEALTH INFORMATION
PLEASE PRINT CLEARLY

Gose Chiropractic
Jonathan Gose D.C. DACBSP, DACRB
22 S Plains Road
The Plains, OH 45780
740-797-4949

Today's Date _____

_____
Whom may we thank for referring you?

Have you consulted a chiropractor before?
( ) Yes ( ) No

_____
If so, whom?

_____
Age

Gender
( ) Male ( ) Female

_____
Birthdate (MM/DD/YYYY)

_____-_____-_____
Social Security Number (Yes, this is required)

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____ _____
Street Address City State Zip Code

( )_____-_____ ( )_____-_____ _____
Cell Phone Work Phone Email Address

Marital Status ( ) Married ( ) Single ( ) Divorced ( ) Widowed Preferred method of contact? ( ) Cell ( ) Email

Do you have insurance coverage? ( ) No - Self(cash) ( ) Yes - Health Insurance or Medicare (please present card and photo ID to staff)

_____ _____
Occupation Employer

_____ ( )_____-_____
Who should we contact in case of emergency? Contact Phone

1. Please describe your PRIMARY COMPLAINT in the space below.

Primary Complaint
The primary symptom/pain that prompted me to seek care today is:
_____
_____

And are the result of (check if applies):
( ) An accident or personal injury
( ) Work ( ) Auto
( ) Other_____

Is your problem getting worse?
( ) No / ( ) Yes, explain _____

Prior interventions (What have you done to relieve the symptoms?)

( ) Prescription medication	( ) Acupuncture
( ) Over-the-counter drugs	( ) Chiropractic
( ) Homeopathic remedies	( ) Massage
( ) Physical therapy	( ) Ice
( ) Surgery	( ) Heat

( ) Other_____
_____

2. Please describe your complaint in further detail below.

How severe is your pain?
On a scale of 1 to 10, with 10 being the worst – please rate your pain.

Circle: 0 1 2 3 4 5 6 7 8 9 10

When did the problem begin?
_____
_____

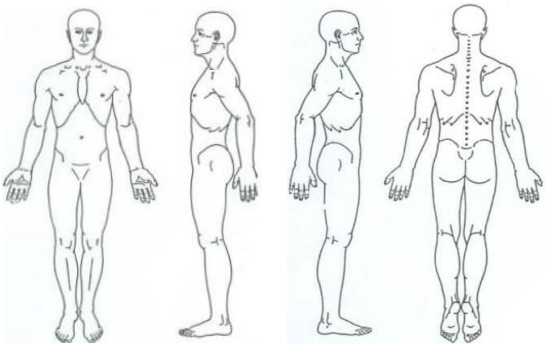
When did you first notice your pain? (First notice your current symptom?)
_____

When is your problem at its worst?
( ) Morning ( ) Afternoon ( ) Evening ( ) Night

Does anything seem to make the pain/problem any better?
( ) No / ( ) Yes, explain _____

How long does your problem/pain last?
( ) Constant pain ( ) On/off pain ( ) Short/quick bursts of pain

Location: Where does it hurt? Circle "O" the areas below



3. What else should Dr. Gose know about your current condition: _____
_____

How does your current condition interfere with your:
Work/career or lifestyle: _____
_____

Recreational activities: _____
_____

Personal relationships: _____
_____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please lace a check mark beside any condition that you've **HAD** or currently **HAVE**.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Osteoporosis	( )	( )	Foot/Ankle pain	( )	( )	Arthritis	( )	( )	Neck pain	( )	( )	TMJ issues	( )	( )	Poor posture
( )	( )	Knee injuries	( )	( )	Shoulder problems	( )	( )	Elbow/wrist pain	( )	( )	Back problems	( )	( )	Scoliosis	( )	( )	Hip disorders

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Anxiety	( )	( )	Depression	( )	( )	Headache	( )	( )	Pins and needles	( )	( )	Dizziness	( )	( )	Numbness

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Cholesterol	( )	( )	Low blood pressure	( )	( )	High blood pressure	( )	( )	Poor circulation	( )	( )	Angina	( )	( )	Bruising

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Asthma	( )	( )	Shortness of breath	( )	( )	Pneumonia	( )	( )	Emphysema	( )	( )	Apnea	( )	( )	Hay fever

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Anorexia/bulimia	( )	( )	Food sensitivities	( )	( )	Constipation	( )	( )	Heartburn	( )	( )	ulcer	( )	( )	Diarrhea

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Blurred vision	( )	( )	Ringing in ears	( )	( )	Chronic ear infection	( )	( )	Hearing Loss	( )	( )	Loss of smell	( )	( )	Loss of taste

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Skin cancer	( )	( )	Psoriasis	( )	( )	Eczema	( )	( )	Acne	( )	( )	Hair loss	( )	( )	Rash

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Thyroid issues	( )	( )	Immune disorders	( )	( )	Frequent infection	( )	( )	Swollen glands	( )	( )	Low energy	( )	( )	Hypoglycemia

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	PMS symptoms	( )	( )	Prostate issues	( )	( )	Erectile dysfunction	( )	( )	Kidney stones	( )	( )	Bedwetting	( )	( )	Infertility

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
( )	( )	Sudden weight Gain/loss (circle one)	( )	( )	Low libido	( )	( )	Poor appetite	( )	( )	Fainting	( )	( )	Weakness	( )	( )	Fatigue

4. Illnesses

Check if you **Have or Had:**

( ) Had	( ) Have	Alcoholism
( ) Had	( ) Have	Allergies
( ) Had	( ) Have	Arteriosclerosis
( ) Had	( ) Have	Cancer
( ) Had	( ) Have	Chicken pox
( ) Had	( ) Have	Diabetes
( ) Had	( ) Have	Epilepsy
( ) Had	( ) Have	Glaucoma
( ) Had	( ) Have	Goiter
( ) Had	( ) Have	Gout
( ) Had	( ) Have	Heart disease
( ) Had	( ) Have	Hepatitis
( ) Had	( ) Have	HIV Positive
( ) Had	( ) Have	Malaria
( ) Had	( ) Have	Measles
( ) Had	( ) Have	Mumps
( ) Had	( ) Have	Polio
( ) Had	( ) Have	Rheumatic fever
( ) Had	( ) Have	Scarlet fever
( ) Had	( ) Have	STD
( ) Had	( ) Have	Stroke
( ) Had	( ) Have	Tuberculosis
( ) Had	( ) Have	Typhoid fever
( ) Had	( ) Have	Other (below)

_____

5. Operations

Surgical intervention, which may or may not have included hospitalization.

( ) Appendix removal
( ) Bypass surgery
( ) Cancer
( ) Cosmetic surgery
( ) Elective surgery: _____
_____
( ) Eye surgery
( ) Gall bladder removal
( ) Hysterectomy
( ) Pacemaker
( ) Spine: _____
_____
( ) Tonsillectomy
( ) Vasectomy
( ) Other: _____
_____
_____
_____

6. Treatments

Check if you've received in the **Past** or are receiving **Currently.**

( ) Past	( ) Currently	Acupuncture
( ) Past	( ) Currently	Antibiotics
( ) Past	( ) Currently	Birth Control Pills
( ) Past	( ) Currently	Blood transfusion
( ) Past	( ) Currently	Chemotherapy
( ) Past	( ) Currently	Dialysis
( ) Past	( ) Currently	Herbs
( ) Past	( ) Currently	Homeopathy
( ) Past	( ) Currently	Hormone replacement
( ) Past	( ) Currently	Inhaler
( ) Past	( ) Currently	Massage therapy
( ) Past	( ) Currently	Physical therapy

7. Allergies to Medication

List all medications you are allergic to: _____
_____
_____
_____

8. Injuries

Have you ever had:
( ) Had fractured or broken bone
Where: _____
( ) Had spine or nerve disorder
Describe: _____
_____
_____
( ) Been knocked unconscious
( ) Been injured in an accident
What part of your anatomy was injured:
_____
_____
( ) Used a crutch or other support
How long? _____
( ) Used neck or back bracing(circle one/both)
How long? _____
( ) Other: _____
_____

9. Current medications (including over-the-counter, natural supplements, enzymes, vitamins, and minerals):

_____

_____

What is your current weight: _____ Height: _____

10. Social History

Alcohol use	( ) Daily ( ) Weekly	How much?_____	
Coffee use	( ) Daily ( ) Weekly	How much?_____	
Tobacco use	( ) Daily ( ) Weekly	How much?_____	
Exercising	( ) Daily ( ) Weekly	How much?_____	
Pain relievers	( ) Daily ( ) Weekly	How much?_____	
Soft drinks	( ) Daily ( ) Weekly	How much?_____	
Water intake	( ) Daily ( ) Weekly	How much?_____	

Hobbies: _____

11. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	( )	( )	( )	( )	Grocery shopping	( )	( )	( )	( )
Rising out of chair	( )	( )	( )	( )	Household chores	( )	( )	( )	( )
Standing	( )	( )	( )	( )	Lifting objects	( )	( )	( )	( )
Walking	( )	( )	( )	( )	Reaching overhead	( )	( )	( )	( )
Lying down	( )	( )	( )	( )	Showering or bathing	( )	( )	( )	( )
Bending over	( )	( )	( )	( )	Dressing myself	( )	( )	( )	( )
Climbing stairs	( )	( )	( )	( )	Love life	( )	( )	( )	( )
Using computer	( )	( )	( )	( )	Getting to sleep	( )	( )	( )	( )
Getting in/out of car	( )	( )	( )	( )	Staying asleep	( )	( )	( )	( )
Driving a car	( )	( )	( )	( )	Concentrating	( )	( )	( )	( )
Looking over shoulder	( )	( )	( )	( )	Exercising	( )	( )	( )	( )
Caring for family	( )	( )	( )	( )	Yard work	( )	( )	( )	( )

12. What is your major stressor in life? _____

13. How mush sleep do you average per night? _____ Hours

14. What is your sleeping position? ( ) Side ( ) Stomach ( ) Back ( ) Recliner ( ) Other _____

15. Describe your normal eating habits: ( ) Skip breakfast ( ) Two meals per day ( ) Three meals day ( ) Snacking b/t meals

16. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

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. This information about your privacy is located on our privacy notice.

Initials_____ I grant permission to be called and/or text to confirm or reschedule appointments and to be sent occasional cards, letters, text, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that I am responsible for the payment of all services here at Gose Chiropractic. I also understand that I must complete the office financial policy/patient payment responsibility form as well before I am seen for treatment.

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 Guardian's) signature Date (MM/DD/YYYY)

Physician's Notes: