CONFIDENTIAL HISTORY FORM - PLEASE PRINT DATE_____

Name _____ Address_____

City/State/Zip_____ Home Phone_____

Social Security #_____ Birthdate_____ Age_____ Male_____Female_____

Number of Children_____ Married_____ Single_____ Divorced_____ Widowed_____

Patient's Occupation_____ Employed by_____

Address_____ City/State/Zip_____

Work phone_____ Email Address_____

Spouse name (or Parent)_____

How were you referred to our office?_____

Have you ever had chiropractic care before?_____

If so, where and when_____

List your chief complaints in order of severity:

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

Date accident happened?_____

Date symptoms appeared?_____

Is this condition getting progressively worse? ☐ Yes ☐ Constant ☐ Comes and Goes or ☐ Better

Is condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

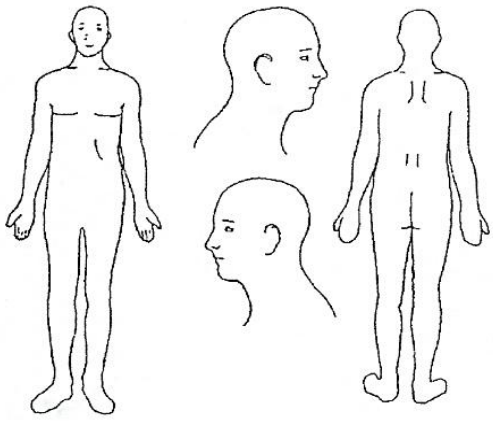
_____

List other doctors consulted for these conditions:

Please check the correct box for any of the following symptoms which you now have or have had before. We want all the facts about your health before we accept your case. **THIS IS A CONFIDENTIAL HEALTH REPORT.**

Before	Now		Before	Now		Before	Now		Before	Now	
☐	☐	Headache	☐	☐	Sore Throat	☐	☐	Chronic Cough	☐	☐	Painful urination
☐	☐	Loss of Sleep	☐	☐	Tonsillitis	☐	☐	Difficult breathing	☐	☐	Prostate trouble
☐	☐	Nervousness	☐	☐	Eye Pain	☐	☐	Wheezing	☐	☐	Pus in urine
☐	☐	Depression	☐	☐	Failing Vision	☐	☐	Inability to control kidneys	☐	☐	Menstrual Cramps
☐	☐	Neck Pain	☐	☐	Epilepsy	☐	☐	Kidney infection	☐	☐	Menstrual Backache
☐	☐	Neck Stiffness	☐	☐	Fever Blisters	☐	☐	Kidney stones	☐	☐	Menopausal symptoms
☐	☐	Pain between shoulders	☐	☐	Allergy	☐	☐	Cancer	☐	☐	Painful menstruation
		Pain or numbness in:	☐	☐	Dizziness	☐	☐	Diabetes	☐	☐	Painful tail bone
☐	☐	Shoulders ☐L ☐R	☐	☐	Fainting	☐	☐	Emphysema	☐	☐	Gout
☐	☐	Arms ☐L ☐R	☐	☐	Fatigue	☐	☐	Heart Disease	☐	☐	Hot flashes
☐	☐	Elbows ☐L ☐R	☐	☐	Chronic Fatigue	☐	☐	Pleurisy	☐	☐	Fever
☐	☐	Hands ☐L ☐R			Syndrome	☐	☐	Pneumonia	☐	☐	Neuralgia
☐	☐	Fingers ☐L ☐R	☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐	Numbness_____
☐	☐	Hips ☐L ☐R	☐	☐	Low Blood Pressure	☐	☐	Gas	☐	☐	Arthritis
☐	☐	Legs ☐L ☐R	☐	☐	Loss of weight	☐	☐	Foot trouble ☐L ☐R	☐	☐	Bursitis
☐	☐	Knees ☐L ☐R	☐	☐	Hernia	☐	☐	Low back pain	☐	☐	Alcoholism
☐	☐	Feet ☐L ☐R	☐	☐	Jaundice	☐	☐	Colon trouble	☐	☐	Hardening of arteries
☐	☐	Crossed Eyes	☐	☐	Liver trouble	☐	☐	Constipation	☐	☐	Poor circulation
☐	☐	Deafness ☐L ☐R	☐	☐	Nausea	☐	☐	Diarrhea	☐	☐	Poor posture
☐	☐	Earache ☐L ☐R	☐	☐	Pain over stomach	☐	☐	Hemorrhoids	☐	☐	Spinal curvature
☐	☐	Ear Noises ☐L ☐R	☐	☐	Poor appetite	☐	☐	Swelling of ankles ☐L ☐R	☐	☐	Swollen joints
☐	☐	Enlarged Thyroid	☐	☐	Asthma	☐	☐	Vericose Veins	☐	☐	Multiple Sclerosis
☐	☐	Hay fever	☐	☐	Colds	☐	☐	Bed-wetting	☐	☐	Polio
☐	☐	Nosebleeds	☐	☐	Chest pain	☐	☐	Blood in urine	☐	☐	Rheumatic fever
☐	☐	Sinus Infection	☐	☐	Panic or Anxiety Attacks	☐	☐	Frequent urination	☐	☐	Stroke

Please mark your areas of pain on the figures below.



Please check if any BLOOD relative has or had any of the following

	Relationship to patient
☐ Diabetes	_____
☐ Heart Problems	_____
☐ Stroke	_____
☐ Cancer	_____
☐ High Blood Pressure	_____
☐ Mental Problems	_____
☐ Back Problems	_____
☐ Epilepsy	_____
☐ Other Illness	_____
	_____
	_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment_____

I hereby authorize Dr. Payne or his assistants to examine me, including x-rays if indicated by the exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and I wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize direct payment to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment or make payment to me.

BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. PAYNE FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.