General Information:

Patient Name: _____ Date: _____
Address: _____ DOB: _____
City: _____ State: _____ Zip: _____ Sex: M F
Cell: _____ Email: _____ Handedness: R L
Orthotic use: Y N

Best time and place to reach you during the day: _____ Marital status: _____
Native language/ ethnicity: _____ SSN: _____
Occupation: _____ Employer/ School: _____

Who may we thank for referring you? _____

Emergency contact (please circle): Spouse other
Name(s): _____
Relationship: _____
Phone: (Home) _____ (Work) _____

Consent & Policies:

I understand and agree to allow Kendrick M. Higo DC, PLLC to use my patient health information for the purpose of examination, payment, healthcare operations and any necessary future treatment or coordination of care. All of the questions in this intake have been answered accurately and fully to the best of my knowledge, and I understand that giving incorrect or false information can be dangerous and adversely affect my care. I agree to pay all in-office fees charged by Kendrick M. Higo DC, PLLC for the healthcare services rendered at the time of service, including a $25.00 fee per any previously missed appointment that I myself cancelled within 24 hours of the originally scheduled time and day, effective upon the start of my treatment. I understand and agree to pay all in-office charges at the time of services being rendered and that fees for in-office services will become immediately due upon suspension or termination of my care or treatment.

I will be paying for in-office services by:
Cash____ Check ____ Credit Card: ____

_____ _____
Patient's Signature (or Guardian) Date

_____ _____
Witness Date

Consent to Treatment of a Minor Child (if applicable):

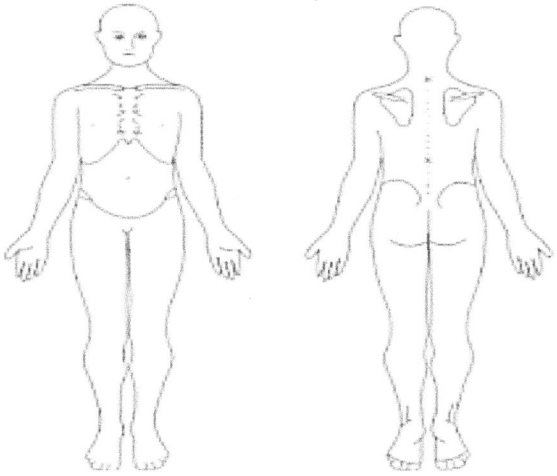
I hereby authorize Kendrick M. Higo DC, PLLC to clinically examine, test, and administer treatment to my child _____ as they deem necessary for his/ her condition and to release any health information pertaining to his/ her treatment to other health providers or third party payers as necessary. This is to serve as long-term authorization and is to apply to all occasions of service until it is revoked in writing.

_____ _____
Guardian's Signature Authorizing Care Date

_____ _____
Witness Date

Kendrick M. Higo DC, PLLC 8990 S. Sheridan Rd, Ste B Tulsa, OK 74133 Ph: (918) 392-7108

Circle all current pain areas:



Circle any pain location, frequency, or intensity you currently have:

Constant (75-100%) **F**requent (50-75%) **I**ntermittent (25-50%) **O**ccasional (0-25%)
L = Left side **R** = Right side **0** = no pain **10**= worst pain imaginable

Head	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Neck	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Shoulder:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Elbow:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Wrist/ Hand:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Midback:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Low back:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Hip:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Knee:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
Ankle/ Foot:	L R	C F I O	0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain: _____

When did it start/ how long has it been present: _____

What caused it: Injury Repetitive use Auto accident Work injury Not sure Other: _____

Has the pain progressed: Gradually Suddenly

Overall, is your condition: Improving Staying the same Worsening

Similar pain experienced before? Yes No If so, when: _____

Have you lost work days? Yes No How many/ describe: _____

Night pain or preventing sleep? Yes No Describe: _____

List any current daily activities limiting you because of pain:
(eg. prolonged sitting/ standing, exercising, driving, work, sleeping, etc.)

_____

_____

_____

Rate how well you can perform each activity from 0 to 10:
(0= not at all 10= at the same level as before the problem started)

_____

_____

_____

What makes the pain BETTER?

Rest General movement Heat/ ice
Pain meds Change in posture Massage/ PT/Chiro
Other: _____

_____

What makes the pain WORSE?

Rest General movement Heat/ ice
Pain meds Change in posture Massage/PT/Chiro
Other: _____

_____

Headaches?	Yes	No	How long: _____ How often: _____ Triggers: _____
Numbness, tingling or painless weakness in fingers or toes?	Yes	No	Describe: _____
Catching or locking?	Yes	No	Describe: _____
Bruising or swelling?	Yes	No	Describe: _____
Painful clicking or popping?	Yes	No	Describe: _____
Changes in bladder, bowel, or sexual function?	Yes	No	Describe: _____
Knees giving out suddenly?	Yes	No	Describe: _____
Dizziness?	Yes	No	Describe: _____
Double vision?	Yes	No	Describe: _____
Jaw pain?	Yes	No	Describe: _____
Ear pain?	Yes	No	Describe: _____
Ear ringing?	Yes	No	Describe: _____
Clumsiness in the arms or legs?	Yes	No	Describe: _____
Fevers, chills, malaise or recent unexplained weight loss?	Yes	No	Describe: _____
Pain coughing, sneezing, or bearing down?	Yes	No	Describe: _____
Have you had any previous chiropractic care in the past?	Yes	No	

What did you like? _____ What did you not like? _____

Other non-chiropractic providers seen for this condition: _____

What are your goals for treatment and care? _____

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Patient name: _____ Sex: M/ F DOB: _____ Date: _____

Review of Systems:

Circle "Yes" (Y) or "No" (N) for experiencing the following signs or symptoms:

Constitutional

Fever Y N
Chills Y N
Malaise Y N
Unexplained weight loss Y N
Changes in appetite Y N
Nausea/ vomiting Y N
Fatigue/ extreme tiredness Y N
Night sweats Y N

Blood/ Immune:

Swollen glands/ lymph nodes Y N
Previous blood transfusions Y N
Frequent infections Y N
blood problems Y N
Unusual skin paleness Y N
Sensation of your heart pounding out of your chest Y N
Weakness Y N
Food allergies Y N
Hives Y N

Skin

Do you tend to bleed or bruise easily? Y N
Growths or lumps Y N
Sores Y N
Rashes Y N
Unusual looking moles Y N
Itching or sensitivity Y N
Dryness Y N
Hives or allergic reactions Y N
Severe acne Y N

Psychological:

Depression: Y N
Mental disorders or conditions Y N

Endocrine:

Problems with glands Y N
Changes in general appearance Y N
Diabetes or personal history of Y N
Constantly feeling hot or cold Y N
Unusual weight loss or gain Y N
Changes in skin Y N
Changes in body hair Y N
Frequent urination Y N
Tremors Y N
Fatigue Y N

Digestive

Abdominal pain Y N
Acid reflux Y N
Belching/ gas Y N
Constipation Y N
Diarrhea Y N
Irritable bowel syndrome Y N
Hemorrhoids Y N
Bloody stools Y N
With diarrhea Y N
With constipation Y N
Black tarry stools Y N
With diarrhea Y N
With constipation Y N
Clay colored stools Y N
With diarrhea Y N
With constipation Y N
Weight trouble Y N
Excessive hunger or thirst Y N
Poor appetite Y N
Liver or gallbladder problems Y N
Yellowing of skin and/ or eyes Y N

Respiratory:

Shortness of breath (SOB) Y N
Any other lung or breathing problems Y N
Productive cough Y N
Coughing blood, sputum or phlegm Y N
Non-productive cough Y N
Wheezing Y N
Chest noises Y N

Neurological:

Progressive weakness Y N
Paralysis Y N
Muscle jerking Y N
Numbness Y N
Loss of sensation Y N
Confusion Y N
Memory loss Y N
Convulsions: Y N
Dizziness Y N
Headaches Y N
Fainting Y N

Cardiovascular:

Chest pain, tightness, or heaviness
Y N
Weakness on exertion
Y N
Dizziness or fainting
Y N
Swelling in feet/ ankles
Y N
Leg cramps
Y N
Cold hands/ feet
Y N
Heart palpitations
Y N
rapid heart rate
Y N
Irregular heart rate
Y N
Hypertension
Y N
Personal history of hypertension or heart disease
Y N
Personal history of bleeding disorders or blood diseases
Y N
Varicose veins
Y N
Skin paleness
Y N
Bruising or skin discolorations
Y N

Musculoskeletal

Arthritis
Y N
General muscle pain through the whole body
Y N
Swollen joints through the whole body
Y N
Spinal curvature problems
Y N
Foot problems
Y N

Genitourinary

Urinary

Pain during urination
Y N
Burning during urination
Y N
Bloody or cloudy urine
Y N
Trouble starting, stopping or holding during urination
Y N
Frequent urinary infections
Y N
Kidney problems
Y N
Increased urination frequency
Y N

Vaginal

Pregnancies
Y N
Abortion
Y N
Miscarriage
Y N
Menstrual
Pain or painful periods
Y N
Cramping
Y N
Absent periods or irregular cycles
Y N
Recent changes in menses
Y N
Bleeding
Y N
Discharge
Y N
Itching
Y N
Hot flashes
Y N
Menopause
Y N
Problems with sexual organ function
Y N

Penile

Pus or drip from
Y N
Sores on
Y N
Problems w/ sex organ function
Y N
Painful or swollen testicles
Y N

Breast

Masses or lumps
Y N
Nipple discharge
Y N
Pain
Y N
Tenderness
Y N
Swelling
Y N
Bleeding
Y N
Do you perform a self-breast exam?
Y N

Head/ Eyes/ Ears/ Nose/ Throat:

Eyes

Discharge
Y N
Redness or inflammation
Y N
Blurring
Y N
Strain or wateriness
Y N
Dryness
Y N
Blind spots
Y N
Double vision
Y N
Decrease or loss of vision
Y N
Recent/ previous infections
Y N

Ears

Pain
Y N
Hearing loss/ changes
Y N
Tinnitus
Y N
Spinning sensations
Y N
Previous hepatitis infections
Y N
Drainage
Y N
Discharge/ runniness
Y N

Nose

Pain
Y N
Stuffy or congested
Y N
Discharge
Y N
Frequent colds
Y N
Head pain
Y N
Bleeding
Y N
Unusual odors
Y N

Throat

Soreness or hoarseness
Y N
Trouble swallowing
Y N
Masses
Y N
Swelling
Y N

Mouth

Sores
Y N
Tongue or mouth soreness
Y N
Tooth pain
Y N
Gum pain
Y N
Trouble chewing
Y N
Bad taste lingering in mouth
Y N

Past Health, Family, Social & Lifestyle History:

In chronological order, please indicate:
Surgeries (past, current):

_____

Injuries, traumas, or motor vehicle accidents (past, current):

_____
_____
_____

Hospitalizations requiring overnight care (past, current):

_____

Serious illnesses (past, current):

_____
_____

Describe any allergies:

_____

Current medications:

_____
_____

Current primary care physician:_____
Location/ Phone: _____
Last general physical exam date: _____
Any problems or changes? Y N
Describe (if applicable):

_____

Describe any previous x-rays, imaging, or lab studies (if applicable):

_____
_____

Describe your typical weekly exercise routine:

_____

Describe your typical daily diet:

_____

Do you feel adequately hydrated throughout the day? Y N

Hours of sleep/ night: _____
Do you wake rested generally? Y N
Any recent changes or problems? Y N

Any recreational, marijuana, IV or OTC drug use? Y N
Describe: _____

Any caffeine use? Y N
Describe source(s): _____
Describe frequency of consumption: _____

Do you drink alcohol? Y N
How many drinks per week? _____
How many drinks per sitting? _____

Do you smoke? Y N
How many packs/ day? _____
How many years total? _____
Are you smoking currently? Y N

Are you or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid? Y N
Describe if necessary:

_____

Contraceptives/ IUD's (if applicable): Y N
Describe:

_____

Date of last menstrual period (if applicable):_____

Please indicate the following:

Mother:
Please circle: Alive deceased
Age: _____
Health concerns: _____

Grandmother (maternal):
Please circle: Alive deceased
Age: _____
Health concerns: _____

Grandfather (maternal):
Please circle: Alive deceased
Age: _____
Health concerns: _____

Father:
Please circle: Alive deceased
Age: _____
Health concerns: _____

Grandmother (paternal):
Please circle: Alive deceased
Age: _____
Health concerns: _____

Grandfather (paternal):
Please circle: Alive deceased
Age: _____
Health concerns: _____

Siblings:
Please circle: Alive deceased
Age: _____
Health concerns: _____

Please circle: Alive deceased
Age: _____
Health concerns: _____

Please circle: Alive deceased
Age: _____
Health concerns: _____

Relatives:
Maternal side:
Please circle: Alive deceased
Age: _____
Health concerns: _____

Please circle: Alive deceased
Age: _____
Health concerns: _____

Paternal side:
Please circle: Alive deceased
Age: _____
Health concerns: _____

Please circle: Alive deceased
Age: _____
Health concerns: _____