TOTALChiropractic HEALTH CENTER

PATIENT HEALTH HISTORY FORM

419 Daniel Webster Hwy – Merrimack, NH 03054-3714
Office: (603) 423-1022 Fax: (603) 423-1023

Name: _____ Referred By: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Complete this form in its entirety and sign where indicated on the last page. We will happily assist you if needed.

CURRENT HEALTH CONDITION – ***Complete this information carefully so the best plan of care can be achieved.***

Chief Complaint (Why are you here today?): _____

_____

_____

When did this condition begin: ____/____/____ Occurred before? □ Yes □ No Explain: _____

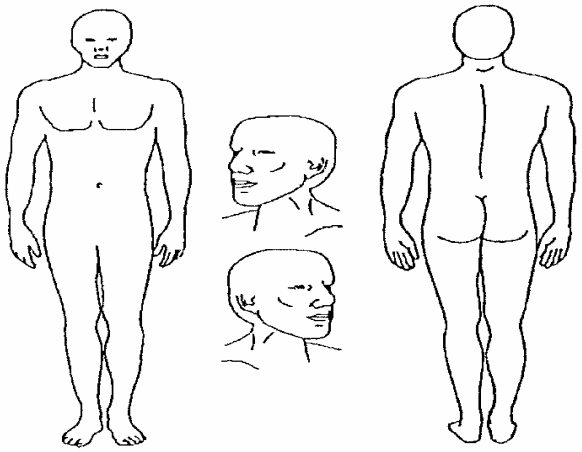
Is this condition related to: □ Auto □ Work □ Home Injury □ Slip/Fall □ Lifting □ Slept Wrong □ Unknown □ Other

Explain: _____

Date of Accident/Injury: _____ Time: _____ am/pm Condition/Pain **STARTED** on what Date? _____

Has this condition occurred before? □ Yes □ No Explain: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us? _____



PLEASE MARK YOU AREA(S) OF PAIN AND DISCOMFORT ON THE FIGURES TO THE LEFT. INDICATE WHICH TYPE OF PAIN YOU ARE EXPERIENCING:

A = SHARP PAIN
B = DULL PAIN
C = BURING PAIN
D = NUMBNESS
E = TINGLING

Previous Care for this SAME CONDITION ~ ***If you answer YES to the following, complete the information below.***

□ YES, I have been treated for this same condition. ~ OR ~ □ NO, I have not been seen for this same condition.

Provider's Name: _____ Specialty: _____

Address: _____ Phone: _____

Type of Treatment: _____

Were you satisfied with the results? □ Yes □ No Explain: _____

Previous Chiropractic Care: □ I HAVE NOT previously seen a Chiropractor ~OR~ Provide the information BELOW.

Doctor's Name: _____ Date of Last Visit: _____

Office Location: _____ Phone: _____

Were your satisfied with your care? □ Yes □ No Explain: _____

Foot Care/Shoe Inserts: □ I DO NOT wear any type of insert or orthotics at this time.

Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Other_____

How long have you been wearing them? _____ Were they prescribed by a doctor? □ Yes □ No

Prescription Medication: **List ALL Medications you are CURRENTLY taking.** Use back of this form if needed.

Below is a list of diseases and past health statements that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Additionally this information is required in medical necessity documentation that is regulated by insurance carriers and federal Centers for Medical Services (CMS) guidelines for contracted provider documentation.

REVIEW OF SYSTEMS – Complete all sections, if it does not apply please mark 'DENY'. Add pertinent information including conditions or diseases that may not be listed. If you need assistance, please let us know.

Constitutional: ☐ I DENY having any symptoms or problems listed below.
☐ Chills ☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Weight Gain
☐ Daytime Drowsiness ☐ Night Sweats ☐ Other_____

Eyes/Vision: ☐ I DENY having any symptoms or problems listed below.
☐ Blindness ☐ Change in Vision ☐ Field Cuts ☐ Photophobia (Light Sensitive)
☐ Glaucoma ☐ Blurred Vision ☐ Tearing ☐ Double Vision ☐ Cataracts
☐ Eye Pain ☐ Itching (around eyes) ☐ Wear Glasses/Contacts ☐ Other_____

Ear/Nose/Throat: ☐ I DENY having any symptoms or problems listed below.
☐ Discharge ☐ Dentures ☐ Fainting ☐ Hearing Loss ☐ Ear Infection (s)
☐ Snoring ☐ Loss of Smell ☐ Sinus Infection ☐ Nasal Congestion ☐ Post Nasal Drip
☐ Hoarseness ☐ Ear Pain ☐ TMJ Problems ☐ Headaches ☐ Nose Bleeds (frequent)
☐ Dizziness ☐ Ear Drainage ☐ Difficulty Swallowing ☐ Sore Throat (frequent) ☐ Loss of Smell
☐ Rhinorrhea (runny nose) ☐ Tinnitus (ear ringing) ☐ Head Injury (history of) ☐Other_____

Lungs/Respiration: ☐ I DENY having any symptoms or problems listed below.
☐ Asthma ☐ Cough (frequent) ☐ Coughing up Blood ☐ Shortness of Breath
☐ Wheezing ☐ Sputum Production ☐ Other_____

Heart/Cardiovascular: ☐ I DENY having any symptoms or problems listed below.
☐ Chest Pain ☐ Angina (chest pain or discomfort) ☐ Claudication (leg pain or ache)
☐ Heart Problems ☐ Orthopnea (difficulty breathing while laying down) ☐ Shortness of Breath w/ Exertion
☐ Heart Murmur ☐ Palpitations (irregular/forceful heart beat) ☐ Swelling of the Legs
☐ Ulcers ☐ Varicose Veins ☐ High Blood Pressure
☐ Paroxysmal Nocturnal Dyspnea (waking at night w/ shortness of breath) ☐ Other _____

Digestive/Gastrointestinal: ☐ I DENY having any symptoms or problems listed below.
☐ Abdominal Pain ☐ Belching ☐ Black/Tarry Stool ☐ Constipation ☐ Hemorrhoids
☐ Rectal Bleeding ☐ Heartburn ☐ Indigestion ☐ Nausea ☐ Diarrhea
☐ Difficulty Swallowing ☐ Vomiting ☐ Vomiting Blood ☐ Jaundice (yellowing of skin)
☐ Abnormal Stool Color ☐ Abnormal Stool Consistency ☐ Abnormal Stool Caliber (quality)
☐ Other _____

Female: ☐ I DENY having any symptoms or problems listed below.
☐Birth Control ☐ Cramps ☐ Irregular Menstruation ☐ Vaginal Bleeding ☐ Breast Lumps/Pain
☐ Frequent Urination ☐ Pregnancy ☐ Urine Retention ☐ Burning Urination ☐Vaginal Discharge
☐ Hormone Therapy (example: fertility, menopause) ☐ Other_____

Male: ☐ I DENY having any symptoms or problems listed below.
☐ Burning Urination ☐ Frequent Urination ☐ Prostate Problems ☐ Erectile Dysfunction
☐ Hesitancy/Dribbling ☐ Urine Retention ☐ Other_____

Glands/Endocrine: ☐ I DENY having any symptoms or problems listed below.
☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Voice Changes
☐ Excessive Thirst ☐ Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth
☐ Abnormal Frequency of Urination ☐ Other_____

Skin: ☐ I DENY having any symptoms or problems listed below.
☐ Changes in Nail Texture ☐ Hair Loss ☐ Itching ☐ Skin Lesions/Ulcers ☐ Hives
☐ History of Skin Disorder ☐ Varicosities ☐ Hair Growth ☐ Rash ☐ Changes in Skin Color
☐ Parenthesis (numbness & tingling) ☐ Other_____

Nerves/Nervous System: □ I DENY having any symptoms or problems listed below.

□ Dizziness □ Facial Weakness □ Headaches □ Limb Weakness □ Loss of Consciousness □ Stress
□ Numbness □ Loss of Memory □ Seizures □ Sleep Disturbance □ Slurred Speech
□ Stroke □ Tremor □ Unsteadiness of Gait/Loss of Balance □ Other_____

Psychological: □ I DENY having any symptoms or problems listed below.

□ Behavioral Change(s) □ Convulsions □ Memory Loss □ Anxiety □ Bipolar Disorder
□ Mood Change(s) □ Depression □ Insomnia □ Confusion □ Appetite Changes
□ Anhedonia (inability to gain pleasure) □ Other_____

Allergy Symptoms: □ I DENY having any symptoms or problems listed below.

□ Anaphylaxis (history of) □ Itching □ Nasal Congestion □ Sneezing □ Rash
□ Food Intolerance □ Other_____

Blood/Hematological: □ I DENY having any symptoms or problems listed below.

□ Anemia □ Blood Clotting □ Bruising Easily □ Bleeding □ Blood Transfusion
□ Fatigue □ Lymph Node Swelling □ Other_____

PAST HEALTH HISTORY

Childhood Illness: Please List All Conditions: □ I DENY any childhood illnesses.

Adult Illness: Please List All Conditions: □ I DENY any adult illnesses.

Surgical History: Please List All Surgeries: □ I DENY any prior surgical history.

Injury History: **LIST ALL prior injuries that apply.** □ I DENY any prior injury history.
Please write the DATE of the surgery immediately after the procedure name that you selected.

□ Back Injury □ Head Injury (w/ Loss of Consciousness) □ Motor Vehicle Accident
□ Broken Bones □ Head Injury (NO Loss of Consciousness) □ Soft Tissue – Mild
□ Disability (is) □ Industrial Accident □ Soft Tissue – Moderate
□ Fall – Severe □ Joint Injury □ Soft Tissue – Severe
□ Fracture □ Laceration – Severe □Other_____

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Allergies: □ I DENY having any allergies**. OR List ALL Allergies**.

I hereby agree that all the information provided by me is complete and accurate to the best of my knowledge. I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for x-rays is for examination only and x-rays negatives will remain the property of this office, being on file where they may be seen at any time while a patient in this office. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature_____ **Date**_____

Complete this section if the information was reported and completed by someone other than the patient:

Representative Printed Name_____ Relationship_____

Representatives Signature _____ Date_____