Millis Family Chiropractic
HEALTH HISTORY FORM

Date _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth _____ Age _____ Gender: F M Social Security #: _____-_____-_____

Marital Status: S M D W L/W Name of Spouse _____

Name and ages of Children _____

Who referred you to our office? _____

For the following categories, please circle what is true for you:

List any **Allergies** (circle all that apply):

Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
Rubber Seasonal Allergies Shellfish Soaps Wheat Other: _____

List any **Surgeries** (circle all that apply and include year surgery was performed):

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

List **ALL Past Medical History** conditions (circle all that apply):

Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
Stroke/Heart Attack Other: _____

List Type of **Medications** you are taking (circle all that apply):

Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
Other: _____

List your **Family History** (circle all that apply):

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition Stroke/Heart Attack
High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Prostate Problems
Other: _____

Have you had any auto or other accidents? ____ No ____ Yes When? _____

Describe: _____

Date of last physical examination: _____ Do you smoke? ___ No ___ Yes

Do you drink alcohol? ___ No ___ Yes - how many per day? _____

Do you drink caffeine? ___ No ___ Yes - how many per day? _____

Do you exercise? ___ No ___ Yes (what forms and how often): _____

Have you ever had chiropractic care? ___ No ___ Yes When? _____ Why? _____

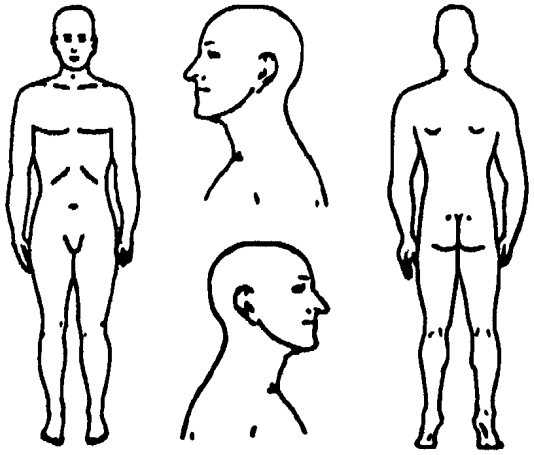
Where? _____ Were X-rays taken? Yes No When was your last adjustment? _____

Reason for this visit

Main reason for consulting the office: ___ Become pain free ___ Explanation of my condition

___ Learn how to care for my condition ___ Reduce Symptoms ___ Resume normal activity level

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ____ GETTING BETTER ____ GETTING WORSE ____ NOT CHANGING

Have you had this condition in the past? ____ NO ____ YES

How often do you experience symptoms? (circle):

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms (circle all that apply): Sharp Dull Numb Burning Shooting Tingling

Radiating Pain Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain):

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? Please describe:

_____

What makes your pain better (ice, heat, massage, etc)? _____

Secondary complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? ____ No ____ Yes

How often do you experience symptoms? (circle):

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms (circle all that apply): Sharp Dull Numb Burning Shooting Tingling

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Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain):

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? Please describe:

_____

What makes your pain better (ice, heat, massage, etc)? _____

Anything else you like to share? _____

_____

_____

FINANCIAL INFORMATION and *AUTHORIZATION*

Payment in full is expected on all FIRST VISIT services.
All other fees are to be paid at time of service unless other arrangements have been made.

Please indicate your method of payment. ❑ Cash ❑ Check

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office.
Complete the following information

❑ Health Ins ❑ Auto Accident ❑ Medicare ❑ Worker's Compensation

Name of Insurance Co: _____

Insured's Name (if different from person receiving care): _____

ID# _____ Policy# _____

Group Name & # _____

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge.

I give Dr. Stephen Stern permission to render care to me today.
This initial visit includes a health history/consultation, chiropractic exam/evaluation,
and any initial care that is determined to be clinically necessary, and mutually agreed upon.
I understand that I am responsible for any balance due that is not paid by Insurance Company.

Patient (Print Name) _____

Signature _____ *Today's Date*_____

Signature of Parent (for minor) _____