Choice Chiropractic & Wellness Center

8074 McIntyre Square Drive - Pittsburgh, PA 15237

Patient Name____ Date ______________________________

SS #/SIN_______________ DOB___________ □ Male □ Female | Phone ___________________________________

Patient's Address _________________________________ City _____________ State_______ Zip________________

Employer Name ____________________________________ Job Title____

Whom may we thank for referring you? ____

Appointment Reminders: _________ Text _________Email Cell phone Carrier : ________________________

Email Address: ____

____ ____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account______________________ Relationship to Patient_____________

Cell Phone _______________________________________ Home Phone_____________________________________

Emergency Contact

Person to contact in case of an emergency______________________________ Phone_________________________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured____ Relationship to patient__________________

Insurance Company_______________________ Group #_____________ ID #__________________________________

Do you have any Worker's Comp / Auto insurance? □ Yes □ No if yes, complete the following:

Name of the insured____ Relationship to patient__________________

Adjustor Name ___________________________________ Phone #____

Insurance Company_______________________ Policy #____

Date of Accident __________________________ Claim #____

Ins. Co. Address__________________________ City_______________ State____________ Zip_________________

Patient Name: ______________________ DOB: ______________ Date: ____________________

Health History

Chief Complaint: ____

History of Present Illness:

Location: ______________________
(Where is the pain/problem?)

Quality: ______________________
(Example: normal vs abnormal color, activity, etc..)

Severity: ______________________
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ______________________
(How long have you had this pain/ problem? When did it start?)

Timing: ______________________
(Does the pain/problem occur at a specific time?)

Context: ______________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ______________________

____
(What other associated problems have you been having?)

Date of Injury ______________ □ work / □ auto / □ other

Modifying Factors ______________________

____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Bladder Infection	NO	YES	High Blood Pressure	NO	YES	Ulcer	NO	YES
Chicken Pox	NO	YES	Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraine Headaches	NO	YES	Hemorrhoids	NO	YES	Thyroid Disease	NO	YES
Scarlet Fever	NO	YES	Tuberculosis	NO	YES	Date of Last Chest X-Ray ____________			Any Other Disease	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	Asthma	NO	YES	(Please List):		
Small pox	NO	YES	Cancer	NO	YES	Hives or Eczema	NO	YES	____________		
Pneumonia	NO	YES	Polio	NO	YES	AIDS & HIV	NO	YES			
Rheumatic Fever	NO	YES	Glaucoma	NO	YES	Infectious Mono	NO	YES	____________		
Arthritis	NO	YES	Hernia	NO	YES	Bronchitis	NO	YES			
Bleeding Tendency	NO	YES	Blood or Plasma			Mitral Valve Prolepses	NO	YES	____________		
Venereal Disease	NO	YES	Transfusion	NO	YES	Stroke	NO	YES			

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
____________	____________	____________
____________	____________	____________

Do you suffer from anxiety or depression? Yes / No If yes, are you under the care of any type of physician or therapist? Yes / No

Medication: (include nonprescription)

____

____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

□ yes □ no if yes what type: ______________________

Patient Social History:

Marital Status	Single: ______	Married: ______	Separated: ______	Divorced: ______	Widowed: ______
Use of Alcohol	Never: ______	Rarely: ______	Moderate: ______	Daily: ______	
Use of Tobacco	Never: ______	Rarely: ______	Moderate: ______	Daily: ______	
Use of Drugs	Never: ______	Type/Frequency: ______________________			

Excessive Exposure
At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: ______ Noise: ______

Do you exercise? Yes / No If yes, how often and what type?

____

CLINICIAN SIGNATURE: ______________________ **DATE REVIEWED:** ______________

PATIENT NAME: ______________________ **DATE:** ______________

Patient Name: ________________________________ DOB: ____________________ Date:_____________________________

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	________	________________________	________________________
Mother	________	________________________	________________________
Siblings	________	________________________	________________________
	________	________________________	________________________
	________	________________________	________________________
Spouse:	________	________________________	________________________
Children:	________	________________________	________________________
	________	________________________	________________________
	________	________________________	________________________

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore Throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromylagia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain between shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/Needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, Tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling Foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ____________________

Signature of the Patient, Parent or Guardian Date

Doctor's Review

____ ____________________

Signature of Doctor Date