PATIENT INFORMATION

Thank you for choosing our office!
In order to serve you properly, we need the following information. Please print.
All information will be confidential.

PITTSBURG CHIROPRACTIC CENTER
. . . Your Wellness Connection

PATIENT INFORMATION

Full Name_____ (Preferred Name)_____ Today's Date_____

Street Address_____ City_____ State_____ Zip_____

Age_____ Date of Birth_____ Social Security Number_____ Email:_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Occupation_____ Employer_____

Emergency Contact (name-relationship)_____ Phone #_____

Marital Status S M D W L/W Significant Other Full Name of Spouse_____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

Or were you referred by: ☐ **Our Website** ☐ **Our Location** ☐ **Phone Book** ☐ **Insurance Co.**

Insurance Co. _____ Policy #_____ Policy Holder_____

REASON FOR SEEKING CHIROPRACTIC/ WELLNESS CARE

What concerns/complaint(s) do you feel Chiropractic can address for you? _____

_____

How long have you had the above concerns/complaint(s)?_____

_____

How often do you have the above concerns/complaint(s)? (constant, frequent, on & off) _____

_____

Is your pain: ☐ sharp ☐ dull ☐ throbbing ☐ numb ☐ achy ☐ burning ☐ pins and needles

Is your concerns/complaint(s) worse: ☐ morning ☐ afternoon ☐ evening ☐ don't notice any change

☐ specific activity _____ ☐other _____

Do you know what caused it?_____

Is it getting: □ better (explain)_____ □worse (explain)_____

Other Symptoms: □ **Headaches** □ **Pins & Needles in Legs** □ **Fainting** □ **Tension** □ **Neck Pain** □ **Loss of Smell**
□ **Irritability** □ **Fatigue** □ **Pins & Needles in Arms** □ **Fever** □ **Back Pain** □ **Loss of Taste** □ **Diarrhea**
□ **Cold Feet** □ **Hands Cold** □ **Numbness in Fingers** □ **Neck Stiff** □ **Short of Breath** □ **Chest Pains**
□ **Numbness in Toes** □ **Stomach Upset** □ **Nervousness** □ **Depression** □ **Constipation** □ **Lights bother eyes**
□ **Memory Loss** □ **Dizziness** □ **Ears Ring** □ **Loss of Balance** □ **Face Flushed** □ **Cold Sweats** □ **Buzzing in Ears**

Is this concern/complaint affecting your quality of life? **Work:** Yes No **Recreation**: Yes No **Sleep:** Yes No
Daily Routine: Yes No **School:** Yes No **Walking:** Yes No **Sitting:** Yes No **Mood:** Yes No
Eating: Yes No **Exercise/Sports:** Yes No **Energy:** Yes No **Relationships:** Yes No

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic Care? Yes No With Whom_____
How long under care? _____Date of Last Visit_____ When did you stop?_____
Was there a particular health concern for which you consulted the chiropractor?_____
_____

Have you consulted or do you regularly consult any of the following care providers? (check all that apply)

□ M.D./ D.O □ Naturopath □ Accupuncturist □ Homeopath

□ Massage Therapist □ Psychotherapist □ Energy Healer □ Dentist

FOR WOMEN ONLY

Are you pregnant? Yes No Date of last Menstrual Period:_____
If x-rays are recommended, your signature is required (below) to indicate that you are not pregnant.
Signature and Date:_____
If pregnant, what is due date?_____ Name of OB/GYN or Midwife_____
Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other_____

HISTORY OF PHYSICAL STRESSES (Birth to Present)

The *birth process* can traumatize a baby's spine and cause damage to the nerve system. Please indicate to the best of your recollection where and how you were birthed. (check all that apply) If you do not know, please skip to the next question.

☐ Home ☐ Natural ☐ Hospital ☐ Caesarian Section ☐ Forceps/Suction

☐ Breech ☐ Cord Around Neck ☐ Prolonged Labor ☐ Drug Induced Labor

The information below will help us to see the types of PHYSICAL stresses that you have been subjected to and how they may relate to your present health status. The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobby related)

Have you had any accidents or trauma related to any of the following? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse
If yes, please explain how and dates:_____
_____

Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips) Yes No

If yes, please explain how and dates:_____
_____

Have you ever broken any bones or sprained any part of your body? Yes No
If yes, please explain how and dates:_____
_____

Were you sick a lot as a child: Yes No Explain:_____

Childhood Sicknesses:_____

Have you ever been hospitalized at any time in your life? Yes No
If yes, please explain for what reason and dates:_____
_____

Have you ever had any surgeries? Yes No If yes, please explain for what reason and dates:_____
_____

CHEMICAL STRESSES

Chemical stress occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body. The following will give us insight into any exposures you may have had.

Have you been exposed to any of the following on a regular basis in the past or presently?

☐ Toxic Chemicals □ Drugs (prescribed or not) ☐ Second hand Smoke ☐other

If yes, please explain:_____

Do you have allergies to any foods? Yes No If yes, please describe:_____

_____

Do you consume any of the following presently? Yes No If yes how much per day:_____ week:_____

☐ Coffee/caffeine ☐ Alcohol ☐ Tobacco ☐ Over the counter drugs ☐ Prescribed drugs

Please list all medications you are taking (prescribed or over the counter):_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

Please list all Supplements (Vitamins/herbal supplements/homeopathics/others) you are taking:_____

_____

_____

Would you be interested in recommendations for nutritional supplements to help your current condition or other health issues? YES NO

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the physical response in our lives from emotional stresses. Please indicate if you have experienced any of the following:

Childhood Trauma	YES	NO	Loss of Loved One	YES	NO	Abuse	YES	NO
Work or School	YES	NO	Divorce/Separation	YES	NO	Financial	YES	NO
Lifestyle Change	YES	NO	Parents Divorce	YES	NO	Illness	YES	NO

PAST HEALTH HISTORY

Have you had any problems in the past or presently with any of the following systems of the body? (describe symptoms or list illness/disease)

Muscle or Skeletal System:_____

Nervous System:_____

Gastro-Intestinal:_____

Cardiovascular:_____

Genito-Urinary:_____

***E*yes *E*ars *N*ose T**hroat:**_____

Male or Female Specific:_____

General: (fatigue/allergies/sleep difficulties/headaches/other)_____

_____

Teeth:_____

Hearing:_____

Sleep Problems:_____ **How many hours/night:**_____

Do you sleep on your: BACK STOMACH SIDE

Do you exercise regularly and how often:_____

What type of exercises do you regularly participate in:_____

Family History:	**Diabetes**	**Cancer**	**Heart Disease**	**Stroke**	**Description**
Father	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	_____
Brother(s) # of ___	☐	☐	☐	☐	_____
Sister(s) # of _____	☐	☐	☐	☐	_____
Adoption History	☐	☐	☐	☐	_____

Ages of family, if they are still living or not, and if not what was the cause of their passing.

Father(____)_____
Mother(____)_____
Paternal Grandmother(____)_____
Paternal Grandfather(____)_____
Maternal Grandmother(____)_____
Maternal Grandfather(_____)_____
Brother(s)_____
Sister(s)_____

WELLNESS OBJECTIVES….Your Wellness Connection

Here at Pittsburg Chiropractic Center, we are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are the closest to your personal health goals: ☐ Symptom/Temporary Relief ☐ Restore Health ☐ Maximum Correction ☐ Wellness & Prevention ☐ Improved Performance

What are your expectations? As a result of my Chiropractic Care, I would like to: (check all that apply)

☐ Feel better quickly ☐ Have a healthier nerve system ☐ Have a healthier spine ☐ Have optimum health on all levels

What is your health philosophy?_____

_____

FINANCIAL INFORMATION

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 and agreed upon in writing. Please indicate your method of payment:

☐ Cash ☐ Check ☐ Credit Card ☐ Insurance Company

I understand that I am responsible for my bill. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.
I authorize use and release of this information on all insurance company submissions.
I authorize my doctor as my agent in helping me obtain payment from my insurance companies/Medicare.
I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.
Wellness services is <u>not</u> a product. Because it is a service your fees are based on the level of services you choose.

This information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Eric Shearer & Dr. Jennifer Holt 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.

Signature_____ Today's Date_____

Signature of Parent (for minor)_____ Today's Date_____