WOODWARD
Chiropractic & Massage
LIVE ACTIVE

Reset Form

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Gender: ☐ M or ☐ F

Name: _____ Email: _____

Date of Birth: _____/_____/_____ Age: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone: _____ Cell: _____Work Phone: _____

Home Address: _____ City, Zip: _____

Occupation: _____ Employer: _____

Name of Emergency Contact / Guardian & Phone #: _____

How did you hear about our office? _____

Appointment Reminders? ☐ Voice Home ☐ Voice Cell ☐ Text ☐ Email ☐ None

Patient Condition:

Describe the reason(s) for your visit: _____

Severity from 1(mild) to 10 (severe): _____at best. _____at worst. Approx. when did this begin? _____/_____/_____

What caused it? _____

What makes your problem better? _____

What makes your problem worse? _____

What does it reduce enjoyment of or limit participation in? (i.e. sleeping, exercising, traveling, time with family, hobbies, etc)

_____

Has there been any change in the following since the onset or relating to your complaint: ☐ **No Change to Any of These**

☐ Balance	☐ Coordination	☐ Grip	☐ Weakness	☐ Breathing
☐ Hearing	☐ Vision	☐ Digestion	☐ Weight	☐ Menstrual
☐ Coughing	☐ Sneezing	☐ Urination	☐ Bowel Habits	☐ Sexual

Past Medical History:

Has this condition occurred before? ☐ Yes ☐ No If yes describe: _____

Have you seen another doctor for this condition? ☐ Yes ☐ No Who? _____

Treatment Received: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Current Family Physician: Dr. _____ Phone: _____ Date of last visit? _____

List **ALL** medications & supplements you take. (Prescription & over-the-counter. Use additional paper if needed)

Drug Name:	Dosage:	How long have you taken & for what conditions?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to **sulfa drugs?** ☐ Yes ☐ No List **ALL** other allergies: _____

CONFIDENTIAL PATIENT INFORMATION – Cont.

List any other **surgeries**, **hospitalizatio**ns or **trauma**s you've had with approx. dates: _____

_____

Systems Review: Check **ALL** you may have had or do currently have now:

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/ Seizures
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Goiter / Thyroid Problems
- ☐ Headaches
- ☐ Heart Attack / Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Blood Sugar
- ☐ HIV/ AIDS
- ☐ Irregular Period/ Cramps
- ☐ Irritable Bowel
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Lyme's Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Severe Neck Pain
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Raynaud's
- ☐ Rheumatoid Arthritis
- ☐ Ringing in the Ears
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Vertigo/ Dizziness
- ☐ Chance currently Pregnant

Due date _____

Family History:

List any diseases / conditions that are common among your family members: _____

_____

Lifestyle: How often do you?

Alcohol: _____ per _____ Tobacco: _____ per _____ Coffee/ Tea/ Caffeine _____ per _____

Exercise: _____ per _____ _____ hrs of Sleep per night

Please list your top 3 major health concerns in order of importance

1. _____
2. _____
3. _____

Authorization & Notice of Privacy Practices:

I understand that my healthcare information is protected under HIPAA Privacy Regulations.

* May we leave a message for you on your answering device? ☐ Yes ☐ No
* May we communicate with a spouse about your appointments? ☐ Yes ☐ No
* May we communicate with your family doctor about your diagnosis/ treatment in our office? ☐ Yes ☐ No

I fully understand that my signature is consent and authorization for Woodward Chiropractic & Massage to perform evaluation and diagnostic procedures on me, or the person for which I am acting as guardian, for the condition(s) described above. I certify all the above questions have been answered truthfully to the best of my knowledge, and do not hold the doctor or clinic responsible for any harm caused due to my failure to disclose information requested on this form that would have otherwise altered their diagnosis and plan of care.

Signature of Patient/ Guardian_____ Date _____

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