GRAND HEALTH CHIROPRACTIC

PATIENT INFORMATION

Last Name:_______________ First Name:_______________ MI:_______

Address:_______________ Apt/Unit:_______________

City: _______________ State:_______________ Zip Code:_______________

Home Phone:_______________ Work Phone:_______________ Cell/Other:_______________

Email Address:_______________

Social Security Number:_______________ Birthdate:_______________ Age:_______ Gender: ○Male ○Female

Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Separated ◻ Widowed Spouse's Name:_______________

Occupation:_______________ Employer:_______________

How were you referred to Grand Health Chiropractic? ◻ Family Member ◻ Friend ◻ Doctor ◻ Other_______________

Please give us the name of the family member, friend or doctor that referred you:_______________

Emergency Contact:_______________ Phone Number:_______________ Relationship to the Patient:_______________

INSURANCE INFORMATION

Insurance Company:_______________ Policy Number:_______________ Group Number:_______________

Policy Holder's Name:_______________ Policy Holder's Birthdate:_______________

Policy Holder's SS#:_______________ Policy Holder's Employer:_______________

Policy Holder's Relationship to the Patient: ◻ Self ◻ Spouse ◻ Parent/Guardian ◻ Other_______________

What are your current complaints?_______________

When did your problem begin?_______________

How did this problem begin?_______________

Is your current injury/condition related to an auto/work accident? ◻ Yes ◻ No If yes, what is the date of the accident?_______________

Please describe your current pain.

◻ Sharp ◻ Dull Ache ◻ Numb ◻ Shooting

◻ Burning ◻ Tingling ◻ Other_______________

Since your problem began, is the pain…

◻ Increasing ◻ Decreasing ◻ Not Changing

How frequent is your pain?

◻ Constantly ◻ Frequently ◻ Occasionally ◻ Intermittently

What makes your problem better?_______________

____

What makes your problem worse?_______________

____

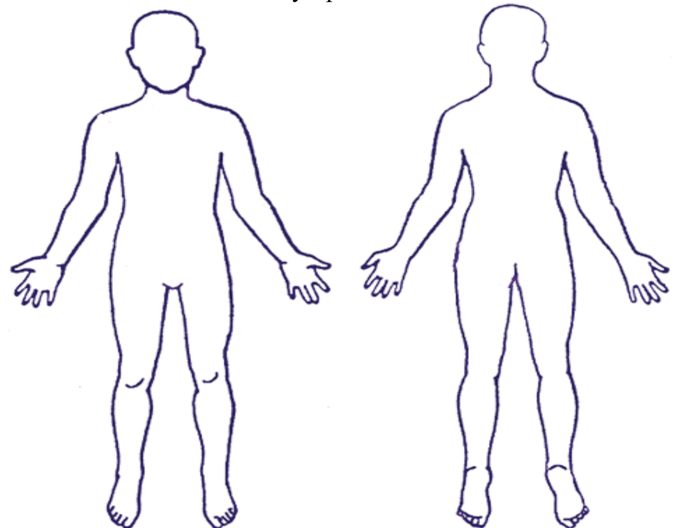
Other health care providers consulted for this condition.

____

Date of last physical examination_______________

Women: Are you or is there a possibility that you may be pregnant?________ If yes, what is the due date?___________

Please mark the location where you have the pain or other symptoms.



Rate the severity of your pain

None										Unbearable
0	1	2	3	4	5	6	7	8	9	10

Please indicate if you have had or presently have any of the following conditions

Cardiovascular

___Fainting ___Heart Disease ___High/Low Blood Pressure ___Irregular Heartbeat ___Phlebitis
___Poor Circulation ___Swelling of Hands/Feet ___Swelling of Legs ___Other______________________________

Ears/Nose/Throat

___Dizziness ___Hearing Loss ___Sinus Infection ___Nose Bleed ___Sore Throat
___Jaw Clicks ___Bleeding Gums ___Difficulty Swallowing ___Other______________________________

Gastrointestinal

___Nausea/Vomiting ___Liver Problems ___Constipation ___Diarrhea ___Ulcers
___Black/Bloody Stools ___Gallbladder Problems ___Bowel Problems ___Other______________________________

Musculoskeletal

___Osteporosos ___Arthritis ___Joint Stiffness ___Muscle Weakness ___Gout
___Broken Bones ___Joints Replaced ___Other______________________________

Respiratory

___Asthma ___Bronchitis ___Cold/Flu ___Cough/Wheezing ___Emphysema
___Difficulty Breathing ___Pneumonia ___Shortness of Breath ___Other______________________________

Eyes

___Glaucoma ___Double Vision ___Blurred Vision ___Color Blindness ___Cataracts
___Glasses ___Eye Pain ___Poor Vision

Genitourinary

___Kidney Disease ___Burning Urination ___Frequent Urination ___Blood in Urine
___Kidney Stone ___Lower Side Pain ___Other______________________________

Neurological

___Stroke ___Seizures ___Severe Headaches ___Numbness ___Head Injury
___Pinched Nerves ___Carpal Tunnel ___Brain Aneurysm ___Other______________________________

Hematologic/Lymphatic

___Hepatitis ___Blood Clots ___Easy Bleeding ___Easy Bruising ___Cancer
___Fever ___Chills ___Sweats ___Other______________________________

Endocrine/Constitutional

___Diabetes ___Thyroid Disorder ___Menstrual Problems ___Other______________________________

___Weight Gain ___Weight Loss ___Difficulty Sleeping ___Other______________________________

Surgeries:____

Serious illness or injury:____

Allergies:____

Medications taken within the last two months (include over the counter and vitamins):____________________________
____

Occupational Stresses:____

Habits: Alcohol (use/week) ________ Tobacco (use/week) ________ Drugs (type, use/week) ____________________

Are there any other issues concerning your health that you would like the doctor to be aware of?_________________________
____

Have you had any other significant traumas? (Auto accidents, falls, etc…):_______________________________________
____

Patient Name (Please Print)____

Name of Person Completing this form____________________________ **Relationship to the Patient**______________

Signature of patient or person completing this form____

Date:________________________