



CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When?

Patient Number
(office use only)

Whom may we thank for referring you?

If so, whom?

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Age

Marital Status

Single Married Divorced
 Widowed Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes No

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?)

4. Intensity (How extreme are your current symptoms?)



5. Duration and Timing (When did it start and how often do you feel it?)

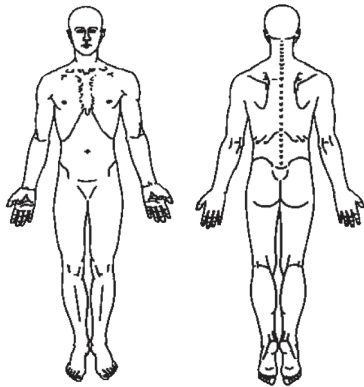
Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)

Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Dr. Miller know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | Initials _____ |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |

b. Neurological

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and needles | <input type="radio"/> Numbness | Initials _____ |

c. Cardiovascular

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive bruising | Initials _____ |

d. Respiratory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breath | <input type="radio"/> Pneumonia | Initials _____ |

e. Digestive

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | Initials _____ |

f. Sensory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infection | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | Initials _____ |

g. Skin

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Eczema | <input type="radio"/> Acne | <input type="radio"/> Hair loss | <input type="radio"/> Rash | Initials _____ |

Patient name _____

Patient Number (office use only) _____

Consultation Notes

Doctor's Initials _____

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Matthew Miller, DC, CCSMS

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h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

Initials _____

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

Initials _____

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE

Initials _____

Patient name _____

Patient Number (office use only) _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL	14. Illnesses Check the illnesses you have Had in the past or Have now.	15. Operations Surgical interventions, which may or may not have included hospitalization.	16. Treatments Check the ones you've received in the Past or are receiving Currently .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	Past <input type="radio"/> Currently <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes		<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy		<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma		<input type="radio"/> Homeopathy
	Had <input type="radio"/> Have <input type="radio"/> Goiter		<input type="radio"/> Hormone replacement
	Had <input type="radio"/> Have <input type="radio"/> Gout		<input type="radio"/> Inhaler
	Had <input type="radio"/> Have <input type="radio"/> Heart disease		<input type="radio"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive		<input type="radio"/> Nutritional supplements:
	Had <input type="radio"/> Have <input type="radio"/> Malaria		List: _____
	Had <input type="radio"/> Have <input type="radio"/> Measles		
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis			
Had <input type="radio"/> Have <input type="radio"/> Mumps			
Had <input type="radio"/> Have <input type="radio"/> Polio			
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever		<input type="radio"/> Medications (prescription and over-the-counter):	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever			
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease			
Had <input type="radio"/> Have <input type="radio"/> Stroke			
	17. Injuries Have you ever...		
	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Miller about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Dr. Miller about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
Hobbies:	_____				

Doctor's Initials _____

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21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only)

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

Signature _____

Date (MM/DD/YYYY) _____

Consultation Notes

Doctor's Initials _____

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