

AFFORDABLE CHIROPRACTIC CLINIC

420 East Armour Road
North Kansas City, Missouri 64116
816-889-9800

PERSONAL HISTORY

NAME _____ DATE _____

SS# _____ - _____ - _____ Birthday ____/____/____ ACCOUNT # _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell _____ Work _____ Other _____

Sex: M F Relationship Status: Married Single Divorced Separated Widowed Partner

Emergency Contact _____ Relationship _____ Phone # _____

Who referred you to my service? _____

Any Previous Chiropractic Care? Y N Last Visit _____ Doctor's Name _____

Who is responsible for payment(s)? Self Pay Spouse Personal Insurance Auto Insurance

Medicaid Medicare Workman's Compensation Other _____

PERSONAL HEALTH INFORMATION

Describe the location of your current pain: _____

When did the pain start? _____ Is this from an accident? Y N Job Related Auto Related

Have you been unable to work? Y N Dates _____

Have you seen any other doctors for your current condition? Y N

Date Seen _____ Doctor's Name _____ Diagnosis _____

Are you taking any of the following: Nerve Pills Pain Killers Muscle Relaxers Blood Pressure Insulin

Ibuprofen Over-the-counter _____ Other _____

Have you ever had any surgeries? Y N Heart Surgery, year _____ Appendectomy, year _____

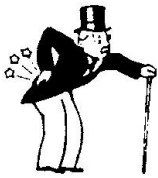
Hernia, year _____ Gallbladder, year _____ Tonsillectomy, year _____

Other surgeries, and what year _____

Have you ever had any broken bones? Y N Which bones/where? _____

Have you been hospitalized in the last 5 years? Y N For what reason? _____

Have you had any major accidents of falls? Y N When? _____



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CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Influenza | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | Other: _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Alcoholism | _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Venereal Infection | _____ |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | _____ |

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/tingling Extremities

GENERAL CODE

- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes
- Varicose Veins
- Ankle Swelling

FEMALES ONLY

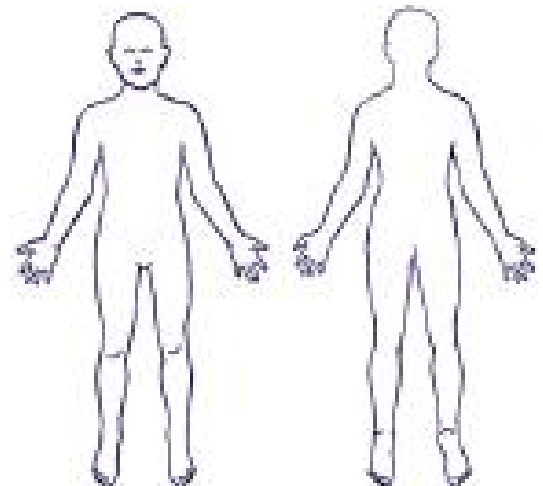
When was your last period?

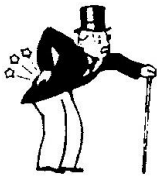
Are you pregnant?
Y__ N__ Maybe__

C-V-R Code

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

Please outline your areas of
discomfort on the diagram:





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WOMEN ONLY

If pregnant in the past, were the pregnancies normal? Y__ N__

Are you seeing an OB/GYN regularly? Y__ N__

Physician's Name: _____

Number of births? _____

Date of last pelvic exam: ____/____/____

Address and Phone of OB/GYN : _____

When was your last mammogram/breast exam? ____/____/____

Who performed it? _____

Do you have difficulty urinating? Y__ N__

Do you have fertility problems? Y__ N__

Do you get headaches? Y__ N__

Do you have indigestion? Y__ N__

Do you perform self-breast exams? Y__ N__

Do you have decreased libido? Y__ N__

Do you have a weak bladder? Y__ N__

Do you have foul flatulence? Y__ N__

Do you have belching? Y__ N__

MEN ONLY

Do you have difficulty urinating? Y__ N__

Do you have decreased libido? Y__ N__

Do you have an enlarged prostate? Y__ N__

MEDICATIONS: (Please check and list all medications you are currently taking with the date you began taking them)

	Medication Name	Date Started	Who Prescribed?
<input type="radio"/>	Antacids	____/____/____	_____
<input type="radio"/>	Antibiotics	____/____/____	_____
<input type="radio"/>	Anti-depressants	____/____/____	_____
<input type="radio"/>	Anti-Diabetics	____/____/____	_____
<input type="radio"/>	Anti-Inflammatory	____/____/____	_____
<input type="radio"/>	Blood Pressure Lowering Meds	____/____/____	_____
<input type="radio"/>	Cholesterol Lowering Meds	____/____/____	_____
<input type="radio"/>	Hormone Replacements (HRT)	____/____/____	_____
<input type="radio"/>	Oral Contraceptives	____/____/____	_____
<input type="radio"/>	Other	____/____/____	_____

For which conditions are you taking the above medications? _____

Are you currently taking any over-the-counter medications? (please list) _____

If so, for which conditions? _____

ALLERGIES: (Please check and list all allergies)

Food: _____

Medications: _____

Seasonal/Other: _____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? Y__ N__ If yes, who recommended them and why are you taking them?

Has anyone ever tested you for supplements? Y__ N__

SCARS/SURGICAL PROCEDURES: (list all you have had) _____

Dental: Do you have any silver amalgam fillings? Y__ N__ If yes, when and where? _____

Have you ever had a root canal? Y__ N__ If yes, how many and when? _____

(DO NOT WRITE BELOW THIS LINE)

Diagnosis: _____

Patient Accepted: Y N

Doctor's Signature: _____