

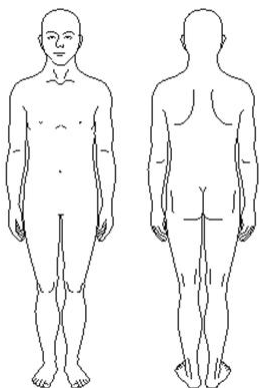
FALLS HEALING ARTS, S.C.

1. PATIENT INFORMATION (OFFICE USE ONLY ACCT# _____) Today's Date _____
Patient Name (First, MI, Last) _____
Address _____ City, State, Zip _____
Phone Home# _____ Work# _____ ext. _____ Cell# _____
Sex ___ M ___ F Age _____ Birthdate _____ SS# _____
___ Single ___ Married ___ Widowed ___ Divorced ___ Other _____ Height _____ Weight _____
Your Employer _____ Full Time ___ Part Time
Are you a student? ___ Yes ___ No ___ Full Time ___ Part Time
How were you referred to our office? _____ E_MAIL _____

2. INSURANCE INFORMATION
___ Cash/Credit ___ Medicare ___ Medicaid ___ Health Insurance ___ Worker's compensation ___ Personal Injury/Auto
Primary Insurance Carrier Name _____
Do you carry a secondary insurance through a spouse/parent? _____

3. ACCIDENT INFORMATION
Is this condition due to an accident? ___ Yes ___ No Date _____
Type of accident ___ Auto ___ Work ___ Home ___ Other _____
Attorney Name (if applicable) _____

4. PATIENT CONDITION
Reason for visit _____
When did your symptoms appear? _____
What caused this problem? _____
What makes the symptoms worse? _____ What makes the symptoms better? _____
Shade and code areas to indicate location of pain or discomfort: (use codes below)



Right View Left View

Numbness	-----
Pins and Needles	+++++
Burning	XXXX
Dull Ache	ooooo
Stabbing Pain	/////

Rate the severity of your pain on a scale from 1 (minimal) to 10 (severe) _____
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your ___ work ___ sleep ___ daily routine ___ recreation
Activities or movements that are painful to perform ___ sitting ___ standing ___ walking ___ bending
___ lying down other _____

IN CASE OF EMERGENCY, CONTACT _____
Phone # _____ Relationship _____

5. AUTHORIZATION/CONSENT TO TREAT:
I authorize and consent to treatment rendered to me/my child at Falls Healing Arts, S.C.

Signature of Patient

Date

Consent to Treat a Minor Child

Relationship

6. HEALTH HISTORY

What treatment have you already received for your condition? medications surgery physical therapy chiropractic
 none other _____

Name and address of other doctor(s) who have treated you for your condition? _____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____ Chest x-ray _____

Dental x-ray _____ MRI, CT-scan, Bone scan _____ Blood Test _____ Urine test _____

Place an X next to "yes" or "no" to indicate if you have had any of the following:

Aids/HIV	<input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	Pinched Nerve	<input type="checkbox"/> yes <input type="checkbox"/> no
Alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	Gonorrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	Pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergy shots	<input type="checkbox"/> yes <input type="checkbox"/> no	Goiter	<input type="checkbox"/> yes <input type="checkbox"/> no	Polio	<input type="checkbox"/> yes <input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Gout	<input type="checkbox"/> yes <input type="checkbox"/> no	Prostate Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Anorexia	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Prosthesis	<input type="checkbox"/> yes <input type="checkbox"/> no
Appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric Care	<input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	Hernia	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatoid Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Herniated Disc	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding Disorders	<input type="checkbox"/> yes <input type="checkbox"/> no	Herpes	<input type="checkbox"/> yes <input type="checkbox"/> no	Scarlet Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Breast Lump	<input type="checkbox"/> yes <input type="checkbox"/> no	High Cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	STD's	<input type="checkbox"/> yes <input type="checkbox"/> no
Bronchitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
Bulimia	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Suicide Attempt	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Measles	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Cataracts	<input type="checkbox"/> yes <input type="checkbox"/> no	Migraine	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsillitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Chemical Dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	Miscarriage	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Chicken Pox	<input type="checkbox"/> yes <input type="checkbox"/> no	Mononucleosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Tumors, Growths	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Multiple Sclerosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Typhoid Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	Mumps	<input type="checkbox"/> yes <input type="checkbox"/> no	Ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Vaginal Infections	<input type="checkbox"/> yes <input type="checkbox"/> no
Fracture	<input type="checkbox"/> yes <input type="checkbox"/> no	Pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	Whooping Cough	<input type="checkbox"/> yes <input type="checkbox"/> no
Hand Dominance	<input type="checkbox"/> R <input type="checkbox"/> L	Parkinson's	<input type="checkbox"/> yes <input type="checkbox"/> no	Other: _____	

EXERCISE

None

Moderate

Daily

Heavy

Are You Pregnant? Yes No

WORK ACTIVITY

Sitting

Standing

Light Labor

Heavy Labor

Due Date: _____

HABITS

Smoking Packs/Day _____

Alcohol Drinks/Wk _____

Coffee/Caffeine Cups/Day _____

High Stress Level Reason _____

7. INJURIES/SURGERIES YOU HAVE HAD

Description

Date

Falls: _____

Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

8. MEDICATIONS / ALLERGIES / VITAMINS / HERBS / MINERALS
