

CONFIDENTIAL HEALTH HISTORY

Today's Date _____

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Last: _____ First: _____ Middle Initial: _____

Address: _____ Apt. #: _____

City: _____ State _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Ext: _____

Cell: _____ E-Mail: _____

Date of Birth: ____/____/____ Age: _____ Social Security #: _____ - _____ - _____

Sex: M F Height: _____ feet _____ inches Weight: _____ pounds

Occupation: _____ Employment Status: FT/ PT Employer: _____

Marital Status: M S W D Name of Spouse: _____ Date of Birth: ____/____/____

Emergency Contact: _____ Phone: _____ Relation: _____

Person Responsible for Account: _____

Referred By: Dex Online Dex Denver Dex Aurora ChiroCareWebsite Internet Ad Coupon Mailer

Previous Chiropractic Care: Yes _____ No _____ If complaint is a result of an injury, check box

Please describe the principal health problems for which you came to this office: _____

Date you first noticed symptoms: _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other _____

List any other doctors seen for this: _____

List any diagnosis(es) and type of treatment(s): _____

Have you lost any days of work? Yes No Dates: _____

Have you had similar accident or injuries before? Yes No If yes, explain: _____

Do you have any allergies or adverse reactions to allergens or drugs? Yes No Please list: _____

Have you been treated for any health condition by a physician in the last year? Yes No If yes, explain: _____

Are you currently under medication? Yes No If so, what kind? _____

List the approximate dates of any surgery, serious accidents, or unusual diseases you have had: _____

Please check the reason for consulting our office. (Please mark one below)

- No Special Problem, I understand the role of Chiropractic in my general health care.
- Disease/Symptom (circle one) and I am ONLY interested in help with this specific problem.
- Disease/Symptom (circle one) and I am interested in help with this specific problem and learning about the role of chiropractic in improving my health.
- Disease/Symptom (circle one) and I am interested in help with this specific problem and learning how to **PREVENT** it in the future.

Insurance Information: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Many insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. I understand that Dr. Truppo will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the aforementioned doctor will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. We accept certain insurance assignments but all insurance arrangements must be approved in advance by the business office.

Patient's Signature: **X** _____ Date: _____

Directions: Please check the appropriate line for any of the following symptoms, which you now have or have had previously. We want all the facts about your health before we accept your case. If you have difficulty, please ask the receptionist.

MUSCULOSKELETAL

- Low back pain, stiffness
- Neck pain, stiffness
- Pain in shoulders
- Pain between shoulders
- Pain in arms
- Pain in elbows
- Pain in hands, wrists, fingers
- Pain in hips
- Pain in legs
- Pain in knees
- Pain in feet
- Bursitis
- Painful tailbone
- Swollen joints
- Foot problems
- Poor posture
- Scoliosis
- Spinal curvature
- Thoracic outlet
- Lumbago
- Fractured bones
- Which ones? _____

NERVOUS

- Convulsions
- Headaches
- Profuse sweating
- Nervousness, depression
- Weakness
- Dizziness
- Fatigue
- Irritable
- Bell's palsy
- Sciatica
- Coma
- Fainting
- Delirium
- Tic
- Tremors
- Trigeminal neuritis

EYE, EAR NOSE & THROAT

- Earache
- Ear noises
- Crossed eyes
- Light bothers eyes
- Nose bleeds
- Sinus problems
- Sore throats
- Hoarseness
- Ear discharge
- Cold sores
- Frequent head colds
- Enlarged glands
- Eye pain
- Failing vision
- Far sightedness
- Glaucoma
- Gum trouble
- Lazy eye
- Nasal obstruction
- Near sighted
- Ringing in ears
- Arthritis

CARDIOVASCULAR/RESPIRATORY

- Chest pain
- Chronic cough
- Difficulty breathing
- Pacemaker
- Swelling of ankles
- High blood pressure
- Poor circulation
- Hands/feet cold
- Consume tobacco _____ packs/day
- Bronchitis
- Spitting up blood
- Spitting up phlegm
- Wheezing
- Angina pectoris
- Arrhythmia
- Heart block
- Heart palpitations
- Low blood pressure
- Pain over heart
- Rapid heart beat
- Slow heart beat

FEMALE

- Lumps in breast
- Vaginal discharge
- Menstrual irregularity
- Congested breasts
- Cramps or backaches
- Menopausal symptoms
- Hot flashes
- Endometriosis
- Excessive menstrual flow
- Painful menses
- Yeast infections
- Date of last menstrual cycle _____

GENITOURINARY

- Bloody urine
- Frequent urination
- Painful urination
- Inability to control urine
- Kidney infection
- Bedwetting
- Pus in urine
- Difficulty urinating
- Dribble
- Impotence

MISCELLANEOUS

- Boils
- Chills
- Drug reaction – which _____
- Dry skin
- Eczema
- Fever
- Multiple sclerosis
- Hemorrhoids
- Influenza
- Bruise easily
- Weight loss
- Knocked unconscious
- Hospitalized
- Sleep on back
- Sleep on side
- Sleep on stomach Warned
- Difficulty sleeping

GASTROINTESTINAL

- Abdominal swelling
- Belching/gas
- Colon problems
- Diarrhea
- Excessive hunger
- Hernia
- Liver
- Vomiting/nausea
- Constipation
- Indigestion
- Consume alcohol
- Consume drugs
- Consume coffee _____ cups/day
- Consume vitamins/minerals
- Colitis
- Craving for specific food
- Intestinal worms
- Pain over stomach
- Poor appetite

OTHER CONDITIONS

- Polio
- Alcoholism
- Epilepsy
- Hives
- Hearing disorder
- Thyroid problems
- Mumps
- Chicken pox
- Itching
- Hay fever
- Anemia
- Emphysema
- Hardening arteries
- Heart disease
- Jaundice
- Paralytic stroke
- Pleurisy
- Pneumonia
- Tuberculosis
- Varicose veins
- Whooping cough
- Asthma
- Rash
- Gout
- Malaria
- Measles

- Rheumatic fever
- Scarlet fever
- Small pox
- Typhoid fever
- Carpal tunnel
- Prostate problems
- Venereal disease
- Appendicitis
- Gall bladder problems
- Low blood sugar
- Thick skin
- Allergies
- Diabetes
- Carpal tunnel
- Prostate problems
- Muscle weakness
- Neuralgia

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