Be Well Corvallis Chiropractic

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	**Age:**
No. of children and ages:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**
Health Insurance Company (Please have us make a copy of your card):	
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	

Who may we thank for referring you? ____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the ***"General Health History"****.*

Health Concerns

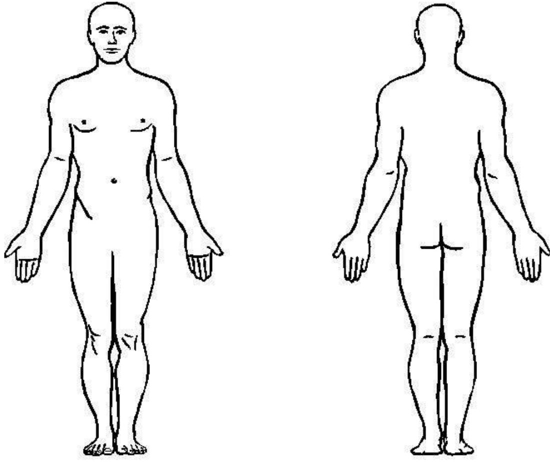
Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain **dull** ☐ **sharp** ☐ **aching** ☐ **throbbing** ☐ Does it **radiate** anywhere, explain? **yes** ☐ **no** ☐

____

____

Mark on the picture the area where you are having localized or radiating pain



Since the problem started is it: **About the same?** ☐ **Getting better?** ☐ **Getting worse?**☐

What have you done for this condition? Was it of benefit?

____

____

Which **activities aggravate** your condition?

____

____

Other doctors you have seen for this condition:

Chiropractor	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Is this condition interfering with any of the following:

Work ☐	**Sleep** ☐	**Daily routine** ☐	**Sports/exercise** ☐	**Other** ☐ (please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you had x-rays taken for the problem(s) you came in with today?

Area of body:	When?	Where?

Current Medicines and Supplements

Please list any medications/drugs you currently take and why: (prescription and non-prescription)

____
____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____
____

Diet

Please mark the dietary selections below, and grade according to the following scale:

D - Consume this daily **W** - Consume this weekly **M -** Consume this monthly **O -** Do not consume this

Alcohol		Eggs		Candy		Artificial Sweetener	
Tobacco		Fish		Diet food		Cooked or canned vegetables	
Coffee		Beef		Refined Sugar		Raw Vegetables	
Diet or Regular Soda		Poultry		Organic foods		Whole Grains	
Fried Foods		Seafood		Fruit		Dairy	
Bread		Pastries		Desserts			

The type of diet I usually follow is classified as: ____

Past Health History

Please mark the following conditions you may have had or have now (use (-) have had, use (+) have now):

☐ Alcoholism	☐ Allergy	☐ Arthritis	☐ Asthma	☐ Back Pain	☐ Cancer
☐ Depression	☐ Diabetes	☐ Epilepsy	☐ Gout	☐ Headaches	☐ Heart Attack
☐ High Blood Pressure	☐ Irregular Periods	☐ Menstrual Cramps	☐ Migraines	☐ Miscarriage	☐ Neck Pain
☐ Nervousness	☐ Ringing in ears	☐Sinus Problems	☐ Stroke	☐ Thyroid Problems	

Other (please explain) ____

I consent to a professional and complete chiropractic examination and to any testing that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ **Date:** ____________________

Signature: ____