Dr. John S. Peterson Chiropractic

Patient Health History

Today's Date ____/____/____ **Signature of Patient**

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name **Nick Name**

Last Name **Middle Name** **Suffix**

Address

City **State** **Zip Code**

Home Phone _____ **Work Phone** _____ **Cell Phone**

E-mail **Create a 4 digit Pin #**

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Home Email ❑ Work Email

Date of Birth ____/____/____ **Age** **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

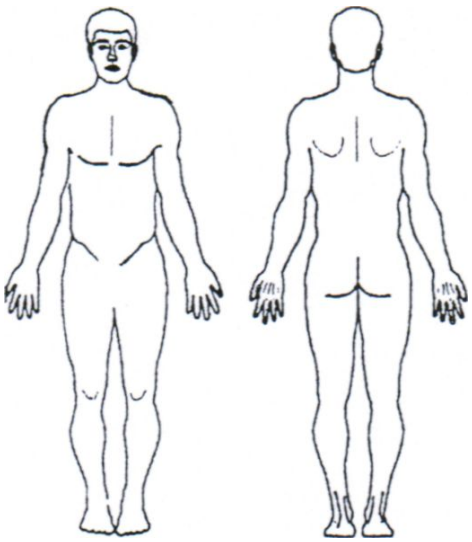
Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN**

Subscriber Name: **Health Plan:** **Subscriber ID #:**

Group #: **Spouse Name:** **Spouse Employer:**

Primary Care Physician Name: **PCP Phone:**

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

_____

Is this? ( ) Work Related ( ) Auto Related ( ) N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**

How often are your symptoms present? ( ) 0 — 25% ( ) 26 — 50% ( ) 51 — 75% ( ) 76 — 100%

Can you perform your daily activities? ( ) Yes ( ) No (Describe)

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ( ) No ( ) Yes Date(s) taken:

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)* **The questions below are required for federally certified EHR.**

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑ Samoan ❑ Guamanian or Chamorro ❑ Other _____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question:

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, Check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) **3)**

2) **4)**

Briefly list your main health problems:

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe:

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes:

To be performed by clinic staff:

Height: _inches **Weight:** _ pounds **BP:** /

Please check all of the following that apply to you: ( ) **None Apply**

No	Yes	Condition	No	Yes	Condition
			( )	( )	**Stroke (date)**
( )	( )	**History of Recent Infection**	( )	( )	**History of Neck Pain**
( )	( )	**Prostate Problems**	( )	( )	**Dizziness/Fainting**
( )	( )	**Recent Fever**	( )	( )	**Arthritis**
( )	( )	**Frequent Urination**	( )	( )	**Numbness in Groin/Buttocks**
( )	( )	**HIV/AIDS**	( )		**History of Alcohol Use**
( )	( )	**Pregnancy, # of births**	( )	( )	**Urinary Retention**
( )	( )	**Diabetes**	( )	( )	**History of Tobacco Use**
( )	( )	**Abnormal Weight ( ) Gain ( ) loss**	( )	( )	**Aortic Aneurysm** ( )
( )	( )	**Corticosteroid Use**	**Surgeries/Medications:**		
( )	( )	**Epilepsy/Seizures**	( )	( )	**Cancer/Tumor**
( )	( )	**Birth Control Pills**	( )		**Recent Trauma**
( )	( )	**Visual Disturbances**	( )	( )	**Osteoporosis**
( )	( )	**High Blood Pressure**			
( )	( )	**History of Low/Mid Back Pain**			

Family History: ( ) Cancer ( ) Diabetes ( ) High Blood Pressure ( ) Heart Problems/Stroke ( ) Rheumatoid Arthritis

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

HIPAA

I have read the Privacy Notice and understand my rights contained in the notice.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I provide Dr. John S. Peterson, D. C. or Dr. David Eskew, D.C. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in Privacy Notice.

DATED: _____Print Name: _____

Signature_____WITNESSES:_____
Signature of Parent or Guardian_____(If a minor) Today's Date Signature of Patient

Smoking: When Started smoking: _____ When Stopped_____

Religion: _____ Mothers Maiden Name: Last _____ First:_____

Employment Information:

Employer Name:_____ Employer Phone:_____

Address Line 1: _____ Address Line 2:_____

City: _____ State:_____ Zip:_____

Next of Kin:

Contact Name: _____Relationship to patient:_____

Address Line 1: _____ Address Line 2: _____

City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____