Patient Name ___________________________ Date _______________

CORNERSTONE CHIROPRACTIC, P.C.
APPLICATION FOR TREATMENT

Date: _________ Name: ________________________________ Date of Birth: __________
Last First M.I.

Address: ___________________________ City: ___________ State: _____ Zip: _________

Phone #: Home ( ) _______________ Work ( ) _______________ Cell ( ) ___________.

Email address: ______________________________________

- ❑ Married
- ❑ Single
- ❑ Widowed
- ❑ Separated

Patient's employer: ________________________________
Address: ____
Type of Insurance *(please present card)*:
□ Health Ins. □ Workers Comp □ Auto Ins □ Home Owner
Name of Insured: ______________________
Insured's Date of Birth: _______________

Person to contact in case of emergency: _____________________________ Tel. #: _____________

Spouse's Name: ______________________________ Date of Birth: ____________

Address *(if different from above)*: _________________________ City: __________ State: ____ Zip: _____

Phone #: Home ( ) _______________ Work ( ) _______________ Cell ( ) ___________.

Spouse's Employer: _____________________________ Spouse's SS #: ____________________

How did you hear about us? (circle one)

Newspaper Ad – which paper? __________________
Phone Book – which book? (please circle)
Indianapolis Yellow Pages
Indianapolis YellowBook
W. Suburban YellowBook
Hendricks County Yellow Pages
Christian Business Phone Book

Postcard
Met Dr. Byrd
Another Dr. _________________
Another Patient _________________
Internet _________________
Event _________________
Other ________________

How will payment be made today? (Please circle) Cash Check Visa MC Discover Other
Have you ever been in an automobile accident? Past year Past 2 years Past 2-5 years Over 5 years Never
Any accidents, falls, or other injuries, that may have caused your problem? ______________________
Please list any surgeries and dates performed: ____
____
Are you pregnant? Y N Date of last menstrual period: _______________
Drugs/Medication you now take: ____
Any chiropractor consulted in the past? Y N Name: ___________________________
Dates consulted: ________________ For what? ______________________________________
Name of family doctor: ____________________ Date last seen: ______________
Reason for visit: ___________________________________
May we send a report of findings to your other doctors? Y N
Would you like Dr. Byrd to pray with you before beginning treatment? Y N

Patient's Signature: _______________________________________ Date: _____________

Social Security #: __________________________

Patient Name ___________________________ Date ______________

Consent for Email Communication

☐ **Yes!** I want my email address added to the mailing list of **Cornerstone Chiropractic P.C.** for future reminders, updates and special occasions.

Email Address:

I, ______________________________, consent to allow **Cornerstone Chiropractic, P.C.** to use my email address for possible future communication. I understand I can be removed from the mailing list at any time by informing the staff at **Cornerstone Chiropractic, P.C.**

Signed Date

Witness Date

Patient Name ___________________________ Date ______________

CORNERSTONE CHIROPRACTIC, P.C.
FINANCIAL POLICY

Thank you for choosing Cornerstone Chiropractic, P.C. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our application for treatment, Assignment for Benefits, and Medical Information Release Authorization forms before seeing the doctor.

- Full payment is due at the time of service.
- We accept cash, checks, Visa/MasterCard and Discover.
- WE offer an extended payment plan with prior credit approval.

Regarding Insurance

We may accept assignment of insurance benefits on those we are in contract with. However, we do require all of your deductible and/or copay to be paid at time of service. ***The balance is your responsibility whether your insurance company pays or not.*** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. All charges may or may not be covered by your particular insurance plan. You are responsible for payment for non-covered DME products such as orthotics, electrodes, supplies given to you from our office. Regardless of your insurance plan's decision whether or not to pay for such items or pay for them partially, you will be responsible for the total bill for these services.

Usual Customary and Reasonable Rates

Cornerstone Chiropractic, P.C. is committed to providing the best treatment for our patients and we charge what is usual, customary and reasonable for our area. Our fees reflect our services, not an insurance company's reimbursement schedule. Certain insurance companies and Medicare may choose not to pay your chiropractic fees in full or in part. This is not uncommon in all health professions and is unfortunate for those affected by this problem.

If your insurance company selects a level of reimbursement (an arbitrary value sometimes referred to as "usual and customary,") which is below our standard fees, they place the responsibility of the remainder of the payment on you when applicable.

The incentive of the insurance company is to hold their costs down. Consequently, they not only determine what is "usual and customary," but they frequently pay only a percentage of a fee THEY select based on your employer contract with them. This sometimes creates a reimbursement schedule significantly below fees charged.

Patient Name ______________________________ Date ________________

These discrepancies created by some insurance companies are unfortunate, but we hope you will recognize that we feel our fees are appropriate. Ultimately, what your insurance carrier pays remains determined by you, the carrier, and contract between your employer and the insurance carrier.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard or Discover, or payment by cash or check at the time(s) that has been verified.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointment at the rate of a normal office visit. Please help us to serve you better and keep costs down by keeping scheduled appointments.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

____

Signature of Patient or Responsible Party Date

____

Signature of Co-Responsible Party Date

Patient Name ___________________________ Date ______________

CORNERSTONE CHIROPRACTIC, P.C.
PAYMENT AGREEMENT

For the services received, the undersigned pledges to Cornerstone Chiropractic, P.C. all balances due on this account from the first day of treatment to the date of the most recent treatment.

The undersigned further agrees that a service charge of one and one half (1.5%) percent per month on any unpaid balance shall be added to any outstanding balance remaining unpaid after ninety (90) days from the date of treatment. The undersigned further agrees to pay all collection fees of any such balance, including reasonable attorney fees and a 35% collection fee on any outstanding balance remaining unpaid after ninety (90) days from the date of treatment.

AUTHORIZATION STATEMENT

I hereby authorize and direct my insurance carrier to pay all benefits that may be due me according to my policy, directly to Cornerstone Chiropractic, P.C. to be applied to my account. I authorize and direct Cornerstone Chiropractic, P.C. to release all medical and account information to my insurance carrier or attorney for claim processing.

I understand and agree that fees for all professional services rendered in my behalf or my dependents' behalf are my personal responsibility and are due and payable at the time services are performed and agree to pay for them. I also acknowledge that I am responsible for any collection fees, including collection agency fees, attorney fees, court costs or any other expenses and fees that incur in any attempt by Cornerstone Chiropractic, P.C. to collect the amount that I owe.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever his is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplication health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a doctor at Cornerstone Chiropractic, P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any ris involved, regarding chiropractic treatment, will be explained to me up on my request.

____

Patient Signature Date

____

Witness

A copy of this signature is as valid as the original.

Patient Name ___________________________ Date ______________

CORNERSTONE CHIROPRACTIC, P.C.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to use by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Name of Patient Date

Patient Name ____________________________ Date _______________

CORNERSTONE CHIROPRACTIC, P.C.
HEALTH HISTORY INTRODUCTION

The entire body works together as one unit. Each part affects another in many different ways. This may be through the nervous, hormonal and/or blood systems, a change in muscle or joint function, or in total body stress. A liver, heart, back or foot does not visit the doctor alone. Rather, the patient is a whole person who is greater than the sum of all of the various body parts functioning together. Diseases or problems in one organ or body part may have far-reaching effects that cause, aggravate or contribute to problems elsewhere, regardless of how seemingly remote or separate they may be.

Examples include:

- Stomach, intestine, colon, pancreas, liver or kidney problems may cause back pain
- Gynecological or menstrual abnormalities may lead to back pain or headaches
- Thyroid disorders, diabetes or hypoglycemia may cause muscle and joint irritability and pain
- Heart, lung or gallbladder disease may present as shoulder pain
- Low back pain problems may give rise to urinary, bowel and/or gynecological problems

At our office, we are determined to find the cause of your pain. It is important to you that we do. We do not just treat the symptoms and hope that the cause, whatever it is, is not serious and will just go away. We do not feel it is right to play guessing games with your health. If we cannot find the cause of your problems and do something to help you, we will refer you to someone who can.

Therefore, you need to complete the following family and personal health history forms as completely as possible. *All information given to us is confidential and will not be revealed to anyone without your consent*. Help us to help you by providing whatever information you can.

Patient Name ______________________________ Date ________________

GENERAL HEALTH HISTORY

Please complete in ink ONLY! Please circle the most appropriate answer(s) unless otherwise specified.

1. General Overall Health

a. Rate your general health: Excellent Good Fair Poor
b. Number of times per week you exercise: ________ / None outside of daily work
c. Average length of each exercise period: Less than 20 min. Less than 45 min. Less than 60 min. 45-90 min. Over 90 min.
d. Which of the following do you perform at least once every two weeks or on a regular basis:
   Aerobics Weight Lifting Walking Bike Riding (In/Out)
   Racquet Sport Swimming Jogging Other: _________________
e. How do you generally handle stress? Very well Well OK Not Well Poorly
f. Any recent illnesses or deaths of a close friend or family? Yes No
g. Have you recently moved, changed jobs, or gotten married or divorced/separated? Yes No
h. How well do you sleep? Like a rock Well OK Toss & Turn Poorly
i. Trouble getting to sleep or often wake up early whether you need to or not?
   Yes No Sometimes

2. Diet/Nutrition

a. Rate your overall diet: Excellent Good Fair Poor
b. Number of meals you eat per day (on average): _______________
c. At what time is the last meal eaten: Before 6pm 6-8 pm After 8pm
d. Number of times you eat red meat: ______ / day OR _________ / week
e. Frequency and form of fruit intake:
   Canned or frozen fruit ________/day OR ______ / week
   Fresh fruit ________ / day OR _______ / week
f. Frequency and form of vegetable intake:
   Canned or frozen vegetable ________/day OR ______ / week
   Fresh vegetable ________ / day OR _______ / week
g. Number of cups of coffee or tea per day: _________
   Please circle: Decaf Coffee Herbal Tea Regular Coffee Regular Tea
h. Number of cans of soda pop per week: _________
   Please circle: Diet Regular Caffeine Free
i. Number of times per week you eat out: _________
j. Glasses of water you drink per day: _________
k. Do you take any vitamin, mineral or herbal supplements? Yes No
   If so, please list: ____

Type	**Amount**	**Reason**

l. Do you drink alcoholic beverages? Yes No

Type	Amount
Beer	Number of bottles per day ___________ / per week __________
Wine	Number of glasses per day __________ / per week __________
Liquor	Number of drinks per day __________ / per week ___________

Patient Name ___________________________ Date ______________

3. Work and Home Life

a. Occupation: __________________________

b. In a typical 8-hour workday you: (circle the number of hours which apply)

Sit:	1	2	3	4	5	6	7	8+
Stand:	1	2	3	4	5	6	7	8+
Walk:	1	2	3	4	5	6	7	8+

c. On the job you perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Squat	□	□	□	□
Crawl	□	□	□	□
Climb	□	□	□	□
Reach above shoulders	□	□	□	□
Crouch	□	□	□	□
Kneel	□	□	□	□
Balance	□	□	□	□
Push/Pull	□	□	□	□
Bend/Stoop	□	□	□	□

d. On the job you lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 lbs.	□	□	□	□
11-24 lbs.	□	□	□	□
25-50 lbs.	□	□	□	□
51-74 lbs.	□	□	□	□
75-100 lbs.	□	□	□	□

e. Do you have to bend over or twist while doing any lifting? Yes No Sometimes

f. Are your feet used for repetitive movements, such as operating foot controls? Yes No

g. Do you use your hands for repetitive actions, such as:

	Simple Grasp		Firm Grasp		Fine Manipulation	
Left Hand	Yes	No	Yes	No	Yes	No
Right Hand	Yes	No	Yes	No	Yes	No

h. Does your work entail any of the following:

	Not at all	Occasionally	Frequently
Computers	□	□	□
Word Processing	□	□	□
Typewriters	□	□	□
Sewing	□	□	□
Telephone	□	□	□
Driving	□	□	□

i. Rate the stress level of your job: Very High High Moderate Minimal

j. How do you feel about your work? Happy & Enjoy It Satisfied & Content Do It Because I Have To Dissatisfied Looking Elsewhere

k. Time spent in the motor vehicle per day: < 30 min. ½ to 1 hour 1 to 2 hours > 2 hours

l. Year and type of automobile driven most often? ______________________

m. Number of Children? ___________ Number living at home? _________

Name and age of each child: a. _______________ b. ______________

c. _______________ d. ______________

Patient Name ____________________________ Date _______________

4. Posture

a. How do you rate your posture: Excellent Good Fair Poor

b. Position and Activity Level maintained most often *after* work: Seated Active Standing Lying Down Relatively Active Inactive Bed

c. Condition of Bed: Very Firm Moderately Firm Average Very Soft Sagging or Flimsy
Waterbed: Full Motion Medium Motion Motionless
Age of Mattress: Less than 2 years 2-5 years 6-10 years Over 10 years
Brand Name: _____________________________________

d. Position maintained most often while sleeping:
On back On stomach On side All over Sitting Up / Reclined

e. Number of pillows used under your head in bed: 0 1 2 3
Type of pillows used under your head in bed: Feather Foam Cervical
Consistency of Pillow: Soft Average Firm Very Firm Cervical Pillow

5. General

a. Type of shoes worn and frequency of wear:

	Not at all	Occasionally	Frequently
Work Boots	□	□	□
Running Shoes	□	□	□
Tennis Shoes	□	□	□
Casual Shoes	□	□	□
Loafer	□	□	□
High Heel Shoes	□	□	□
Pumps	□	□	□

b. Heel height of shoes worn most frequently: < ½” 1 1½” 2” > 2”

c. Religion or beliefs (optional): ____________________________________

d. Hobbies: ____
____
____

Patient Name ___________________________ Date ______________

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member (NOT YOU!). Leave blank those spaces that do not apply. Please list grandparents, aunts or uncles on the reverse side of this form as they apply. CIRCLE your answers if your relative lives around this locality as some conditions are affected or caused by similar climate and environmental factors.

CONDITION	FATHER AGE ( )	MOTHER AGE ( )	SPOUSE AGE ( )	BROTHER(S) AGE ( )	AGE ( )	SISTER(S) AGE ( )	AGE ( )	CHILDREN AGE ( )	AGE ( )	AGE ( )
Allergies										
Arthritis										
Asthma – Hay Fever										
Back Trouble										
Bowel Problems or Colitis										
Cancer (type, if known)										
Carpal Tunnel Syndrome										
Diabetes/Hypoglycemia										
Disc Problem										
Emphysema/Lung Problems										
Epilepsy/Seizures										
Flat or Painful Feet										
Headaches										
Heart Trouble										
High Blood Pressure										
Kidney Trouble										
Liver Trouble										
Lupus/Schleroderma										
Migraine										
Muscle Disease/Problems										
Multiple Sclerosis										
Neck Pain										
Neuritis or Neuralgia										
Osteoporosis/Weak Brittle Bones										
PMS/Painful Periods										
Pinched Nerve (location, if known)										
Scoliosis										
Shoulder Problems										
Sinus Trouble										
Stomach Trouble/Ulcers										
Thyroid Problems/Goiter										
Other Problems										

If any of the above family members are deceased, please list their age at death and cause: __________________________
____
____
____

Patient Name ___________________________ Date ______________

PERSONAL HEALTH HISTORY

All information given to us is confidential and will not be revealed to anyone without your consent. It is very important that you complete this to the best of your ability so that we may properly assess your case! Please add as many details as you possibly can. Please complete every section even thought it may not appear to apply to your problem.

Please Complete in Ink Only.

1. General

	Yes	No	
a.	□	□	Gained or lost more than 10 lbs. in the last year. Number of lbs. ___________ Reason (circle): Appetite: Increase/Decrease Exercise: Increase/Decrease Food Intake: Increase/Decrease
b.	□	□	Fever or chills – either persistent or recurring?
c.	□	□	Sweat excessively at night. (circle) past or present?
d.	□	□	Allergic to: ___________________________
e.	□	□	Anemia (low blood count or iron-poor blood)? When: _______________
f.	□	□	Sickle Cell Trait or Thalassemia
g.	□	□	Bruising or Bleeding? (circle) easy or excessive?
h.	□	□	Blood diseases or problems: ________________________

2. Endocrine or Hormonal System

	Yes	No	
a.	□	□	Heat/Cold Intolerance (circle)
b.	□	□	Cold hands/feet (circle)
c.	□	□	Thyroid problems (goiter/other problems with the gland in your neck) When & specify type: ________________________________
d.	□	□	Diabetes or high blood sugar / Hypoglycemia Diagnosed by & date: ________________________________ Managed by & dose: _________________________________
e.	□	□	Adrenal problems or ever taken cortisone? When & what for: ____________________________________
f.	□	□	Other: ____

3. Eyes, Ears, Nose & Throat

	Yes	No	
a.	□	□	Glasses or contacts? (circle) Nearsighted/Farsighted Last time prescription was checked: ___________________
b.	□	□	Itchy, red or painful eyes
c.	□	□	Difficulty hearing or deafness – left or right ear (circle)
d.	□	□	Ringing in ear(s) – left or right ear (circle)
e.	□	□	Nosebleeds
f.	□	□	Hoarseness
g.	□	□	Sinusitis – past or present (circle)
h.	□	□	Dizziness or sensation of room spinning around. When? _____________
i.	□	□	Dental problems (circle those which apply) ▪ More than four fillings ▪ Gum disease – past or present ▪ Pain or clicking in jaw when chewing, talking or any other time (TMJ problems) ▪ Dentures – upper or lower ▪ Other _________________________
j.	□	□	Tonsillectomy/Adenoidectomy – date: _______________
k.	□	□	Frequent tonsil, throat or ear infections (circle)
l.	□	□	Chew tobacco or snuff (circle)
m.	□	□	Infectious Mononucleosis – date: ________________
n.	□	□	Other: ____

Patient Name ____________________________ Date _______________

4. Gastrointestinal System (bowels, stomach, liver, pancreas, spleen)
   - a. □ □ Nausea / Vomiting – when: ________________
   - b. □ □ Peptic ulcer – diagnosed by and date: ______________
   - c. □ □ Trouble or pain with swallowing or getting food down
   - d. □ □ Heartburn or indigestion – with which foods: _________
   - e. □ □ Abdominal or belly pain – when: ______________
   - f. □ □ Diarrhea or Constipation (circle)
   - g. □ □ Frequency of bowel movement: ____ x / _____ day(s)
   - h. □ □ Color and consistency of stool (circle all that apply)
     black & tarry light brown dark brown medium brown sticky
     hard red green firm & formed soft watery & loose
   - i. □ □ Any recent change in frequency or consistency of stool?
     Specify: ____________________________________
   - j. □ □ Stools that float
   - k. □ □ Colitis (Crohn's disease, ulcerative, mucous or spastic)
     Diagnosed by: ______________________________
   - l. □ □ Hernia – inguinal L or R – femoral L or R – umbilical – hiatal
     Diagnosed by and date: _______________________
   - m. □ □ Hemorrhoids or piles
   - n. □ □ Gallbladder / liver / pancreas problems (circle) Specify: ______________
   - o. □ □ Appendectomy – date: _____________________
   - p. □ □ Cancer – where and when: _____________________
   - q. □ □ Other: ___________________________

5. Lungs and Respiratory System
   - a. □ □ Shortness of breath or trouble breathing – when _________________
   - b. □ □ Cough or sputum production
     Color (circle): clear white yellow brown red green
   - c. □ □ Wheezing or asthma (circle) past or present
   - d. □ □ Tuberculosis (check yes if exposed or had abnormal test)
     Date of last test or exposure to TB: ___________________
   - e. □ □ Date of last chest x-ray: _______________
   - f. □ □ Pneumonia/Pleurisy/Bronchiectasis (circle) – date: _______________
   - g. □ □ Emphysema or bronchitis (circle) – date: _____________
   - h. □ □ Smoking
     Number of years you have or had smoked: ___________
     Number of packs/day: ___________
     Year quit (if applies): ___________
     Other: Pipes, Cigars ___________
   - i. □ □ Exposed to any fumes, chemicals, smokes, acids, or gases
     Type & Location: ___________________________
   - j. □ □ Other: ____

6. Cardiovascular System (Heart and blood vessels)
   - a. □ □ Trouble breathing (when lying down or waking up)
   - b. □ □ Palpitations (pounding, fluttering, racing, or skipping a beat)
   - c. □ □ Edema or swelling – location: _______________
   - d. □ □ Pain, discomfort, fatigue in legs when walking or exercising
   - e. □ □ High blood pressure – diagnosed by & date: ___________
   - f. □ □ Past heart/valve disease or heart murmur (circle)
   - g. □ □ Angina/heart attack (circle) – date: _____________
   - h. □ □ Chest pain – date of last episode: _____________
   - i. □ □ Heart or bypass surgery – date: _____________
   - j. □ □ Other: ____

7. Genitourinary System (Genitals, kidney, bladder)
   - a. □ □ Number of times urinated/day: _____________
   - b. □ □ Pain with urination: ____________

c. □ □ Wake up at night to urinate - # of times: ___________
d. □ □ Blood in urine – when: ______________
e. □ □ Difficulty starting urination right away
f. □ □ Can get 80% of urine out without stopping and starting
g. □ □ Incontinence/inability to retain urine (leaking) – when: ______________
h. □ □ Bladder or kidney infection (circle) – date: ______________
i. □ □ Prostate problems – enlarged/infection/cancer/other (circle)
Diagnosed by & date: ______________________________
j. □ □ Other: ____

8. Skin
a. □ □ Itching – location: ___________________
b. □ □ Rash – location: ___________________
c. □ □ Moles changing color or size – location: _________________
d. □ □ Skin cancer / melanoma – location & date: _______________
e. □ □ Moles/skin lesions removed – location & date: ____________
f. □ □ Psoriasis – location: ________________
g. □ □ Acne/warts – location: _______________
h. □ □ Atopic dermatitis/eczema (circle) – location: ______________
i. □ □ Other: ____

9. Neurological Systems (Brain, nerves, spinal cord)
a. □ □ Headaches – migraines, tension, sinus, etc. (circle)
b. □ □ Epilepsy or seizures (circle)
c. □ □ Transient numbness/tingling in the hands, feet, or elsewhere
Where: _____________________
d. □ □ Transient loss of consciousness, fainting or blackouts
When: ____________________
e. □ □ Weakness – location: __________________
f. □ □ Ever hit or fall on your head – date & specifics: ___________
g. □ □ Strokes/transient ischemic attacks – date: _____________
h. □ □ Multiple Sclerosis/Myasthemia Gravis/Parkinson's (circle)
i. □ □ Meningitis/Shingles – Location & date: __________________
j. □ □ Carpal tunnel syndrome or neuritis – location & date: ______
k. □ □ Other: ____

10. Musculosketal System (Joints, muscles, nerves)
a. □ □ Past injuries, sprains, strains or problems (circle L or R and date)
Feet – L/R: ____________ Ankle – L/R: ____________
Knee – L/R: ____________ Leg – L/R: ____________
Hip – L/R: ____________ Hand – L/R: ____________
Wrist – L/R: ____________ Elbow – L/R: ____________
Shoulder – L/R: __________ Arm – L/R: ____________
Head – L/R: ____________ Neck – L/R: ____________
Ribs & Chest – L/R: _______ Tailbone – L/R: __________
Other – L/R: ____________
b. □ □ Osteoporosis or brittle weak bones
Diagnosed by & date: _____________________________
c. □ □ Fractures/dislocations – location & date: _______________
d. □ □ Past accidents (auto or other) or trauma
Location & details __________________________________

e. □ □ Participation in contact sports or any of the following:
Football Hockey Wrestling Gymnastics
Rugby Boxing Ballet Martial Arts
Car or Bike Racing Other: _________________
f. □ □ Past back pain (circle) neck upper back mid back low back
g. □ □ Past spine, neck, or nerve surgery – Date & location: _________________

h. □ □ Problems with feet (circle) flat feet foot deformity bunions
painful feet foot or ankle swelling neuroma other: ________________

i. □ □ Arthritis – rheumatoid, osteoarthritis (circle)
Diagnosed by and location: ______________________

j. □ □ Rheumatic fever / Gout (circle) Date: ____________________

k. □ □ Other: ____

11. Emotional History (past or present)

a. □ □ Schizophrenia / Psychotic
b. □ □ Neurotic
c. □ □ Manic Depressive
d. □ □ Anxiety
e. □ □ Depression
f. □ □ Other: _____________________

12. Hospitalizations/Medications

a. □ □ Hospitalizations (include date, location and reason):
____

b. □ □ Current medications (over the counter or prescription):
Name Dose Frequency Reason
____
____

c. □ □ Frequency of pain killer use: ________/day _______/week

d. □ □ Use of any of the following, even occasionally: (circle)
Marijuana Heroin No-Doz Cocaine Speed Other

e. □ □ Alcoholism – past or present

13. Sexual History

a. □ □ Difficulties or pain with sex – due to: __________________
b. □ □ Problems with scrotum/penis
c. □ □ Birth control methods (circle):
birth control pill diaphragm condoms spermicidal cream
vasectomy (date _________) tubal ligation (date _________)

14. Breast (this applies to both men and women)

a. □ □ Self-examine your breasts
b. □ □ Lump or mass in breast(s) – L/R – When: _______________
c. □ □ Breast discomfort/pain – When: ______________
d. □ □ Nipple discharge (circle) clear white yellow red other
e. □ □ Fibrocystic disease – Diagnosed by and date: ___________
f. □ □ Breast cancer – L/R – When: __________________
g. □ □ Date of last mammogram: _________ Normal/Abnormal
h. □ □ Date of last breast exam: _________ Normal/Abnormal
i. □ □ Other: ____

15. Female Genitalia (gynecological/obstetrical history)

a. □ □ Pelvic pain – when: ____________________
b. □ □ Vaginal discharge (circle) clear white yellow green
c. □ □ Ovarian cyst/problems – Diagnosed by & date: __________________
d. □ □ Uterine problems or fibroids
e. □ □ Painful menstrual periods/Premenstrual syndrome (circle)
f. □ □ Endometriosis – Diagnosed by & date: ________________
g. □ □ Gynecologist (name & date): _________________________
h. □ □ Uterine or ovarian cancer – Date: ___________________
i. □ □ Uterus/ovaries removed (circle) – Date & Reason: _________

j. Menstruation History

- Age Periods Began: _______ Age Periods Ended: ________
- How regular are your periods? (circle)

Very Regular Somewhat Regular Irregular

- # of days between the beginning of periods: (circle)

  <26 27 28 29 30 31 >31

- Date of last normal menstrual period: __________

k. PAPS History

- Date of last Pap smear: ________ normal/abnormal (circle)

l. Pregnancy

- # of pregnancies: ______
- # of live births: ______