ABOUT HEALTH CHIROPRACTIC
Holistic Healing Center

Welcome to Dr Kaplan's Office

Date _____

First Name _____ Last Name _____ Middle Initial _____
Address_____ City _____ State _____
Zip _____ Occupation _____
Soc Sec _____ Date of Birth_____ Sex ____
Marital Status _____
Home Phone _____ Cell Phone _____
E-mail address_____
Who may we thank for referring to our office? _____
List your major health problems/concerns:
1. _____
2. _____
3._____
4. _____

Describe the causes of these concerns (if known or suspected)

_____
_____
_____
_____

Have you had the same (or similar) problem before (circle one)? **Y/N**
What activities aggravate your problem(s)?_____
_____
What activities improve your problems(s)? _____
_____
Are your problems getting progressively worse?Y/N
Are your problems interfering with (*check all that apply)*
Work ____ Daily Routine ____ Sleep ____ Other _____

Who is responsible for this account? _____
Is this case covered by insurance? YES NO If yes please present your card for photocopying

I authorize the release of any medical information necessary to process to process this claim, I also request payments of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services.

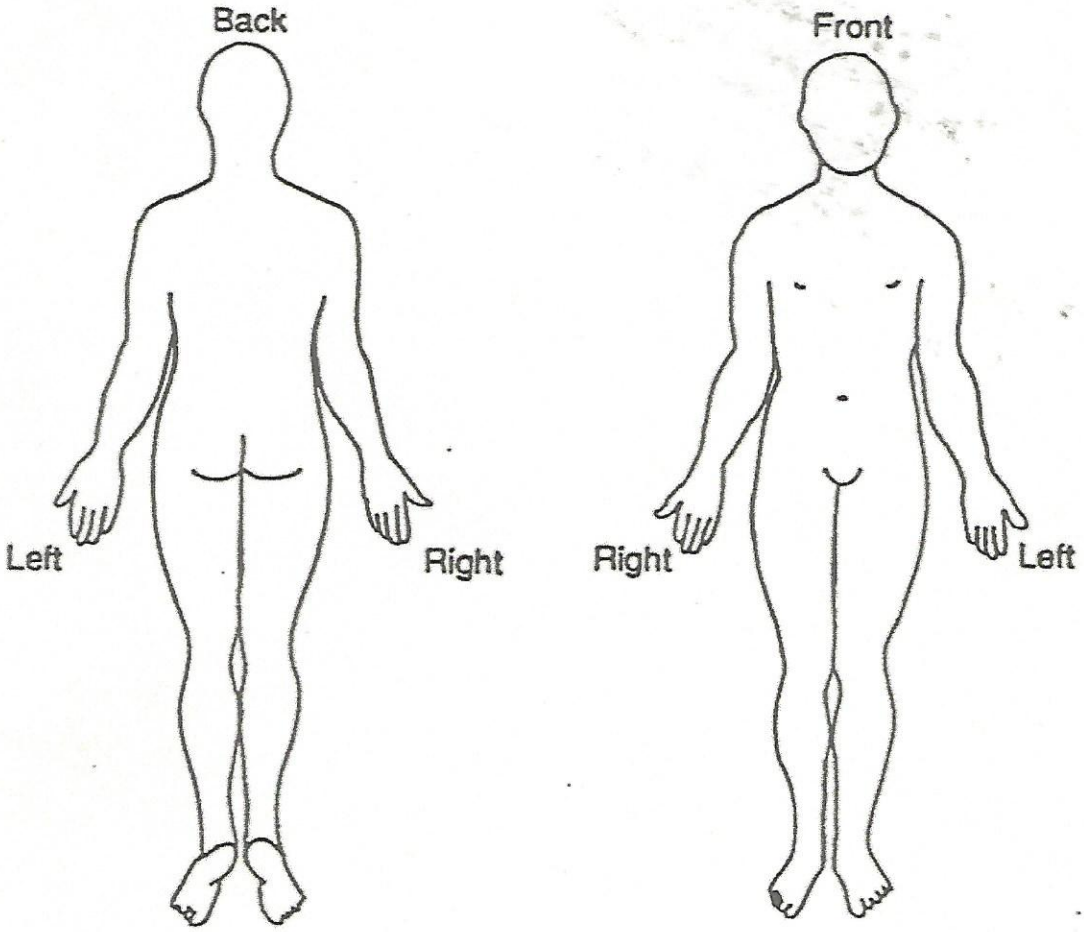
Signature _____ Date _____
(If patient is a minor, name of parent or guardian)

PAIN DIAGRAM

Name: _____ Date: _____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-A
Burning-B
Numbness-N
Pins and Needles-P
Stabbing-S
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling ***at this time***.

Date: _____

1 — 10

NO PAIN — WORST PAIN IMAGINABLE

Previous Treatment for Health Problems

Were you previously treated for the above problems? Y / N
*(if no, skip to **Health Maintenance Update** section below)*
Name of practitioner _____
Date first seen _____ Date last seen _____
List tests that were done, including X-rays _____
List pertinent test results _____
Condition or diagnosis _____
How was the condition treated _____
Results of treatment: ☐ Good ☐ Fair ☐ Poor
Please list below other practitioners seen for this condition: (or check here for none ____)

	Name	Date (approx.)	Testing/Treatment
1.			
2.			
3.			
4.			

Additional remarks about previous treatment _____
_____
Current primary care physician _____
Do you suffer from any other health problems from which you are not seeking consultation with us?
Y / N If yes, please itemize below:

	Condition	Date of onset (approx.)	Practitioner
1.			
2.			
3.			

Health Maintenance Update

Please indicate approximate dates and results of last:
Physical exam _____
Spinal exam _____
Dental exam _____
Cholesterol profile _____
Other blood tests _____
Chest X-ray _____
Spinal X-ray _____
Bone density (DEXA) scan _____
Mammogram _____
Eye exam _____
Colonoscopy or flexible sigmoidoscopy _____
Other _____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

List medication/supplement/environmental allergies or intolerances and associated reactions:

List past or present exposure to harmful chemicals:

Surgical History

Please list all major and minor surgeries you have undergone with approximate dates:

Previous Chiropractic Care

Have you previously had chiropractic care? Y / N *(if no, skip to **Serious Accidents** section below)*
Chiropractor_____
Date first seen_____ Date last seen_____
Under treatment for what condition at that time _____
Were X-rays taken? Y / N If yes, please indicate approximate date and region(s) X-rayed:

_____
Cause of condition as explained by doctor _____
Results of treatment: ☐ Good ☐ Fair ☐ Poor

Serious Accidents and Falls

Have you ever been in an auto accident? Y / N Date(s) _____
Describe _____
Have you had any significant sports injuries? Y / N Date(s) _____
Describe _____
Have you had any work accidents? Y / N Date(s) _____
Describe _____
Please describe any other accidents, falls, or injuries (include dates):

_____

_____
Please list all fractures you have sustained and when they occurred:

_____

_____

Early Health History

List any known problems your mother had during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery):

_____

_____
Were you breast fed? Y / N. If *yes*, please indicate duration if known _____
Was your home life as a child loving/supportive? Y / N
If there were significant stresses please describe _____

_____
Please check if you had any of the following childhood illnesses:
☐ Frequent ear infections ☐ Colic ☐ Eczema ☐ Recurrent colds ☐ Bronchitis
☐ Pneumonia ☐ Meningitis ☐ Other _____
As a child were you on frequent or prolonged antibiotic therapy? Y / N
Did you receive immunizations? Y / N
Did you experience any adverse reactions to immunizations? Y / N / NA
If *yes*, please describe _____

Please check all of the following conditions that you have experienced:

— Alcohol/drug addiction
— Allergies
— Anemia
— Anxiety, reoccurring
— Asthma
— Blood fats, high (cholesterol, triglycerides)
— Blood pressure, high
— Blood pressure, low
— Bone loss
— Cancer
— Depression
— Diabetes
— Emphysema
— Environmental sensitivities
— Epilepsy
— Fatigue, chronic
— Gallstones
— Headaches, reoccurring
— Heart attack
— Heart disease
— Heart palpitations
— Insomnia
— Kidney disease
— Mental health problems
— Pneumonia
— Sexually transmitted infection
— Sinus congestion, chronic
— Skin problems
— Thyroid disorder
— Ulcer
— Urination problems
— Other (please describe):
_____
_____

Female Health History

Age at first period ____ Date of last period _____
Number of pregnancies ____ Number of live births ____
Date of last Pap test _____ History of abnormal Pap tests? **Y / N**
History of irregular periods? **Y / N** Menstrual cycle length: ____ days.
Duration of menstrual period: ____ days.
Do you experience significant menstrual cramping? **Y / N**
Is heavy bleeding a problem? **Y / N**
Do you have a history of endometriosis? **Y / N**
Do you have a history of yeast infections? **Y / N**
Do you have a history of infertility? **Y / N**
Do you have excessive unwanted hair growth? **Y / N**
Do you have a tendency toward premenstrual syndrome? **Y / N**
If yes, please describe symptoms: _____
Do you have a family history of (*check all that apply*): ☐ breast cancer ☐ ovarian cancer ☐ osteoporosis
Describe any current menstrual or menopausal symptoms or concerns:

_____
Describe any current breast problems: _____
Did you breast feed? **Y / N** *If yes, please indicate duration for each child:* _____

Digestive Function

Describe any food intolerances you have: _____
_____
Describe any digestive problems: _____
_____
Your usual bowel movement frequency is (*check one*):
☐ >2 times daily ☐ 1 time daily ☐ 1time every 2 days ☐ <1 time every 2 days.

Do you usually have to strain to have a bowel movement? **Y / N**
Are your bowel movements chronically loose? **Y / N**
Do you ever have blood with bowel movements? **Y / N**
Are your stools ever black or tarry? **Y / N**
When was the last time you received antibiotics? _____

Family Health History

Review the conditions below. Indicate if a family member has ever had a condition with an 'X' in the appropriate space. Leave blank any spaces that do not apply.

CONDITION	**Father** Age ___	**Mother** Age ___	**Spouse** Age ___	**Brother(s)** Age(s)___	**Sister(s)** Age(s)___	**Children** Age(s)___
Acne						
Alcoholism/addiction						
Allergies/hay fever						
Alzheimer's Disease						
Arthritis						
Asthma						
Bedwetting						
Cancer (*specify type* _____)						
Depression						
Diabetes						
Digestive problems						
Ear infections						
Female problems						
Headaches						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Muscle pain/cramps						
Osteoporosis						
Spinal curve						
Thyroid problems						
Other (*specify* _____)						
Other (*specify* _____)						
If any of the above family members are deceased, please list their age at death and specify cause of death.						
Other pertinent family history:						

Stress Factors

Please indicate if any of the major stresses listed below apply to you *(check all that apply)*:
☐ Job ☐ New retirement ☐ New baby ☐ Change of marital status ☐ Health problems
☐ Family stress ☐ Financial concerns ☐ Abusive relationship ☐ Other: _____.

Please describe the quality of major relationships in your life: _____
_____.

Indicate job satisfaction (if applicable): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you experienced physical, emotional, sexual, or verbal abuse? Y / N

Lifestyle Habits

Describe your sleep pattern: Time arise _____ Time retire _____ Naps? Y / N
Your quality of sleep is: ☐ Well-rested ☐ Tired upon awakening ☐ Awaken during night
Do you: ☐ Sleep in total darkness ☐ Sleep near electric clock, outlet, or other electronic device
Your typical sleep position is: ☐ Side ☐ Back ☐ Stomach Is your mattress firm? Y / N
Pillow type *(check all that apply)*: ☐ Firm ☐ Soft ☐ Thick ☐ Thin ☐ Feather ☐ Synthetic ☐ Orthopedic
What is the frequency of your vacations: ____ times / year.
How frequently do you travel: ☐ Annually ☐ Semi-annually ☐ Monthly ☐ Weekly
Do you live/work in a damp or moldy home/office? Y / N
Do you exercise? Y / N
If *yes*… Type: _____ Frequency: ____ times per week/month (*circle one*).
How do you relax or relieve stress? _____
_____
Do you use tobacco? Y / N If *yes*, list amount you smoke/chew per day and week _____
Years using tobacco _____, if you no longer use it, when did you quit _____
Do you use recreational drugs? Y / N If *yes*, list type and frequency _____
Did you formerly use recreational drugs? Y / N If *yes,* specify _____

Diet History

Describe your typical:
breakfast _____ lunch _____
dinner _____ snack _____
How frequently do you dine out: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How frequently do you eat fast food: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How much water do you drink daily: ☐ < 1 qt. ☐ 1 qt. ☐ 2 qt. ☐ > 2qt.
Is it filtered water? Y / N
Foods you avoid and why (*i.e.* allergies, diet, dislike): _____
Foods you crave: _____
Do you have (or have you had) an eating disorder? Y / N
Do you drink coffee? Y / N if *yes*, how many cups daily of decaf _____ and caffeinated _____
Do you drink tea? Y / N if *yes*, what kind _____ and how many cups do you drink daily ____
Do you drink soda? Y / N if *yes*, what kind _____ and how many do you drink daily _____
Do you drink alcohol? Y / N if *yes*, list type and amount per day and week _____
Do you have (or have you had) a problem with alcohol overuse? Y / N