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Established Patient History Update

Name: _____ Date: _____
(First) (Middle) (Last)

Home Address: _____ City: _____ St: _____ Zip: _____

HomePhone: _____ WorkPhone: _____ CellPhone: _____

Student Status: ___ FT ___ PT Employment Status: ___ FT ___ PT Marital Status: ___ S ___ M ___ D

Date of Birth: ____/____/____ Sex: ___ M ___ F

Spouse's Name: _____ Best Contact Number: _____

Emergency Contact: _____ Phone: _____

Email Address: _____

Payment Information

I will be paying today by: Cash Check Credit Card Auto Insurer WC insurer

I authorize NeuroTarget Chiropractic, LLC the release of any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to NeuroTarget Chiropractic, LLC. I authorize NeuroTarget Chiropractic, LLC to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged \$30.00 for each returned check. If I choose to use my non-contract insurance company, I will be considered a cash patient by NeuroTarget Chiropractic. Payment for professional services are due at the time of service. After paying in full I will receive a receipt with the appropriate billing and diagnosis codes to submit to my insurance company myself. My insurance company will reimburse me directly. I certify the information above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Chief Complaint – Present Condition

What is bringing you to the office today? _____

When did your complaints and/or symptoms begin? _____

What caused the onset of your condition? _____

Describe the condition (ache, sharp, burn, tight)? _____

Is your condition improved worsening staying the same since the onset?

What makes your condition worse? _____

What helps your condition? _____

How often or when does your condition occur? _____

Does your condition radiate or affect other areas? _____

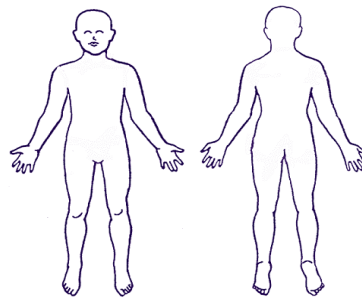
Have you had this condition before? _____

Is your condition interfering with: sleep work daily activities other _____

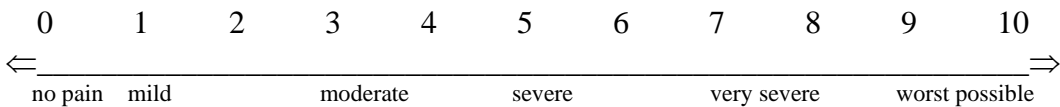
Have you received treatment for this condition? _____

Please mark your symptoms on the diagram.

- Aching – XXX
 Burning - ###
 Numbness - ///
 Pins/Needles – 000
 Stabbing - ●●●



Rate your pain right now (mark as “N”); worst (mark as “W”); best (mark as “B”)



Please check all present symptoms related to your current condition:

Head & Face

- | | | | | | |
|--|--|--|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Base of skull | <input type="checkbox"/> Side/temple | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Incapacitating | <input type="checkbox"/> Front | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Eyelids heavy | <input type="checkbox"/> Top |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Pressure | <input type="checkbox"/> Head feels heavy | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Flushing |
| <input type="checkbox"/> Light sensitive | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Headache affects vision | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus problems | |

Neck

- | | | | | | |
|-----------------------------------|---------------------------------------|---|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Spasms | <input type="checkbox"/> Pain on motion | <input type="checkbox"/> Limited motion | <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Throat tight | <input type="checkbox"/> Radiating pain | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Stiffness | |

Shoulder, Arm & Hand

- Shoulder: Local pain Limited movement Pain on movement Pain from neck Radiates down arm
- Arm & Hand: Local pain Pain on movement Swelling Cold hands Weakness
- Radiates from neck Numbness/tingling Cannot raise arm

Mid-back & Low-back

- | | | | | | | | |
|---|---|---------------------------------|-----------------------------------|-------------------------------------|------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Pain | <input type="checkbox"/> Spasms | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Pain on motion |
| <input type="checkbox"/> Limited motion | <input type="checkbox"/> Radiating pain | | | | | | |

Hips, Legs, Knees and Feet

- | | | | | | | | |
|-------------------------------------|------------------------------------|------------------------------------|---|---|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Local pain | <input type="checkbox"/> Radiating | <input type="checkbox"/> From back | <input type="checkbox"/> Down leg | <input type="checkbox"/> Swelling | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Spasms |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Weakness | <input type="checkbox"/> Pain on motion | <input type="checkbox"/> Varicose veins | | | |

Nerves

- Burning Numbness Tingling Tremor Dizziness Loss of balance Loss of consciousness
 Coordination Twitching Difficulty with memory Seizures Generalized weakness

Sleep

- Good Fair Poor Poor due to pain Deep burning pain
 Difficulty falling asleep Difficulty staying asleep Wake often

Fatigue

- Must rest during day Cannot get enough rest Intermittent fatigue Constant fatigue
 Worse with exercise Mental fatigue Physical fatigue

Past Medical History

Please mark any of the following that you have experienced in the **past 6 months**

General

- Weight loss Weight gain Night sweats Change in appetite Chills
 Fever Insomnia Fatigue Itching Spots on fingernails
 Fragile/brittle nails Headaches Skin rash/sores Excessive thirst Bruise/bleed easily

Head, Eyes

- Pain at base of skull Pain on side of head Temporal pain Pain on top of head Migraine
 Vision loss Blurred vision Double vision Poor night vision Eye pain Red eye

Ears, Nose and Throat

- Ear pain Ear discharge Hearing difficulty Ringing in ears Earache/infections
 Loss of smell Nose bleeds Nasal discharge Postnasal discharge Sinus pressure
 Sinus congestion Sore throat Oral sores Dental problems Tooth pain
 Bleeding in gums/lips Hoarse voice Neck pain

Cardiovascular and Respiratory

- Chest pain/tightness Palpitations Swelling of legs/feet Leg pain Low blood pressure
 High blood pressure Cold hands/feet Irregular/fast heartbeat Fainting Varicose veins
 Shortness of breath Dizziness Coughing blood Lung problems
 Persistent cough Wheezing Snoring Lightheaded

Gastrointestinal

- Nausea Vomiting Heartburn Gas/bloating Bloody stools
 Bright red stools Black tarry stools Esophageal reflux Constipation Hemorrhoids
 Ulcers Diarrhea Gallbladder problem Bowel incontinence Abdominal pain/cramps

Genitourinary

- Pain with urination Frequent urination Kidney stones Loss of bladder control Infection
 Wake to urinate Blood in urine Sexual dysfunction Urgency with urination STD
 Incomplete bladder emptying

Male/Female Systems

- Prostate problems Testicular pain Swelling in the scrotum Sexual dysfunction
 Irregular periods Vaginal pain/infection Vaginal bleeding Menopause Menstrual cramps
 Breast pain/lumps ___ # of pregnancies ___ # of live births ___ # of C-Sections

Name: _____ DOB: _____

Musculoskeletal

- Joint pain Muscle pain Back stiffness Joint stiffness Back pain
- Muscle stiffness Joint swelling Difficulty with limb movement

Skin

- New rashes/moles Non-healing sores Skin itch Hair loss

Neurologic

- Headache Muscle weakness Numbness Coldness Crawling/prickling
- Memory loss Seizures/convulsions Dizziness Confusion Paralysis

Psychiatric

- Anxiety Sadness Irritability Insomnia Suicide

Endocrine

- Heat intolerance Cold intolerance Excessive thirst Excessive hunger

Hematologic/Lymphatic

- Easy bleeding Easy bruising Bleeding disorder Lymph node enlargement

Allergic/Immunologic

- Hives Seasonal allergies Environmental allergies HIV exposure

Have you had an allergic reaction to the following?

- Latex and rubber Bee or wasp stings Adhesive tape
- Iodine or x-ray contrast dye Influenza vaccination other: _____

Do you have any food allergies? Yes No If yes, please list: _____

Have you ever been hospitalized? Yes No
If so, where and when? _____

Please list your surgery(ies) None

Date	Type of Surgery	Results

Are you taking any medication? Yes No If yes, please complete table below:

Medication Name	Dosage	How Often Taken	How long have you been taking this medication?

Are there any medications you have had an allergic reaction or unpleasant side effects? _____

Name: _____ DOB: _____

Are you currently taking any supplements? Yes No If yes, please complete table below:

Supplement Name	Dosage	How Often Taken	How long have you been taking this medication?

Substance Review:

Do you use tobacco? Yes No
Previously used? Yes No

Pack per day _____ # of years _____

Do you use Alcohol? Yes No
Previously used? Yes No

Servings per day _____ Days per week _____ # of years _____

Do you use Caffeine? Yes No

Servings per day _____ Days per week _____ # of years _____

Self-Care/Home Environment Assessment:

In an average week, how many minutes of moderately vigorous physical activity do you get?

none 1-30 31-60 61-120 121-180 181-240 241-300 300+

Do you have any special dietary needs or food sensitivities? Yes No

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known, I will tell the doctor when possible so that it can be added to my record.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

(please sign, print your name and relationship to the patient)