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Established Patient History Update

Name:____ Date:________________
(First) (Middle) (Last)

Home Address:____________________________City:________________St:____Zip:__________

HomePhone:_________________WorkPhone:__________________CellPhone:________________

Email Address: ____

Date of Birth: _____/______/________ Sex: __ M __ F

Student Status: ___FT ___PT Employment Status: ___FT ___PT Marital Status: ___ S___M___D

Spouse’s Name: _____________________________Best Contact Number:_____________________

Emergency Contact:______________________________________Phone:____________________

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: _____________

Name:______________________ DOB:____________

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? ____

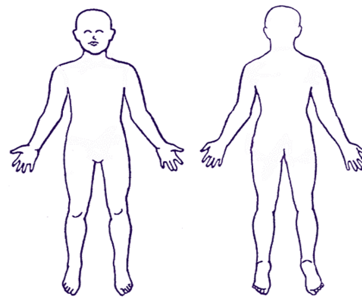
Have you had this condition before? ____

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

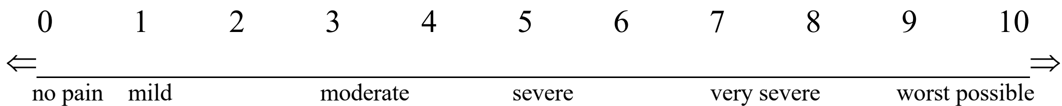
Have your received treatment for this condition? ____

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 <u>current</u> condition:

Head & Face

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

Neck

Weakness	Spasms	Pain on motion	Limited motion	Pain	Swelling
Lumps	Throat tight	Radiating pain	Difficulty swallowing	Stiffness	

Shoulder, Arm & Hand

<u>Shoulder</u>: Local pain Limited movement Pain on movement Pain from neck Radiates down arm

<u>Arm & Hand</u>: Local pain Pain on movement Swelling Cold hands Weakness

Radiates from neck Numbness/tingling Cannot raise arm

Mid-back & Low-back

Weakness Pain Spasms Rib pain Chest pain Stiffness Swelling Pain on motion

Limited motion Radiating pain

Hips, Legs, Knees and Feet

Local pain Radiating From back Down leg Swelling Numbness Tingling Spasms

Cramping Cold feet Weakness Pain on motion Varicose veins

Name:______________________ DOB:____________

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

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 Pack per day _______# of years ________
Previously used? Yes No

Do you use Alcohol? Yes No Servings per day _____ Days per week ______ # of years______
Previously used? Yes No

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)