Lundgren
FAMILY CHIROPRACTIC

File # _____

Date: _____

Patient Health History

2965 13th Avenue
Rock Island, IL 61201

In order to provide you the best possible chiropractic care, please complete this form as accurately as possible. All information is strictly CONFIDENTIAL.

Patient Data:

First Name: _____ MI: _____ Last: _____ Email: _____

Address: _____City: _____ State: _____ Zip: _____

Phone (home)_____ (cell)_____ (work): _____

Age: _____ Birth Date: _____ SSN#: _____ Sex assigned at birth: _____

Occupation: _____ Employer: _____

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse: _____ # Children _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred by: _____ or How did you hear about us? _____

Medical Doctor: _____ City: _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name: _____ Date of Last Adjustment: __/__/__

Financial Information:

☐I will be paying for the service myself ☐ Health Insurance ☐ Auto Insurance ☐ Worker's Compensation ☐ Other

Insurance Company:_____

Policy #: _____ Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Purpose of this Visit:

Reason for this visit: _____

When did your symptoms start? _____

How did you injure yourself? _____

Please select all that apply:

☐ Achy	☐Radiating	☐ Stabbing	☐ Constant (75-100% of the day)
☐ Burning	☐ Sharp	☐ Stiffness	☐ Frequent (50-75% of the day)
☐ Dull	☐ Shooting	☐ Tingling	☐ Intermittent (25-50% of the day)
☐ Numbness	☐ Soreness	☐ Other	☐ Occasional (0-25% of the day)

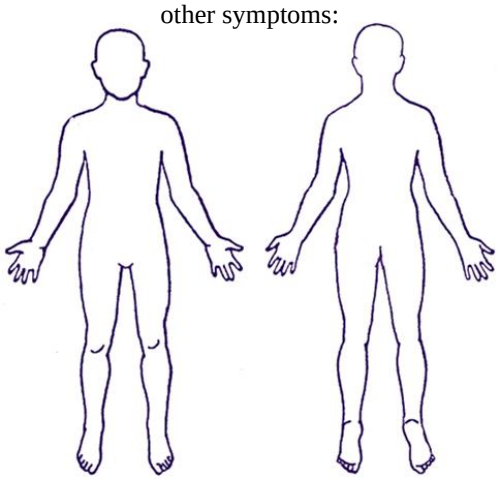
Intensity of your symptoms: (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

The symptoms improve when I… _____

The symptoms worsen when I… _____

This prevents me from… _____

Please indicate where you have pain or other symptoms:



Comments: _____
_____

Who have you seen for your symptoms? ☐ No one ☐ Chiropractor ☐ Physical Therapist

☐ Surgeon ☐ MD ☐ Other

What treatments/tests were performed: (X-Rays, MRIs, etc.) _____

Past History:

Have you ever experienced this problem? ☐ Yes ☐ No Please state: _____

Have you ever had any surgery? ☐ Yes ☐ No Please state: _____

Have you ever had any car accidents? ☐ Yes ☐ No Please state: _____

Sports injuries, falls, broken bones? ☐ Yes ☐ No Please state: _____

Do you take any medication? ☐ Yes ☐ No Please list: _____

Do you smoke? ☐ Yes ☐ No Packs per day: _____

Do you consume alcohol? ☐ Yes ☐ No # drinks per week _____

Do you exercise? ☐ No ☐ Infrequently ☐ Occasionally ☐ Frequently ☐ Regularly

Average hours worked per week: _____ hours

Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Anticipated Due Date: ___/___/___

Please check all that you have or have had:

☐AIDS	☐Alcoholism	☐Allergies	☐Anemia	☐Arteriosclerosis
☐Arthritis	☐Asthma	☐Back Pain	☐Breast Lump	☐Bronchitis
☐Bruise Easily	☐Cancer	☐Chest Pain/Conditions	☐Cold Extremities	☐Constipation
☐Cramps	☐Depression	☐Diabetes	☐Digestion Problems	☐Dizziness
☐Excessive Menstruation		☐Eye Pain/Difficulties	☐Fatigue	☐Frequent Urination
☐Headache	☐Hemorrhoids	☐High Blood Pressure	☐Hot Flashes	☐Irregular Heart Beat
☐Irregular Cycle	☐Kidney Infection	☐Kidney Stones	☐Loss of Memory	☐Loss of Balance
☐Loss of Smell	☐Loss of Taste	☐Migraine Headache	☐Neck Pain or Stiffness	☐Nervousness
☐Nosebleeds	☐Pacemaker	☐Polio	☐Poor Posture	☐Prostate Trouble
☐Sciatica	☐Shortness of Breath	☐Sinus Infection	☐Sleep Problems/Insomnia	
☐Spinal Curvatures	☐Stroke	☐Swelling of Ankles	☐Swollen Joints	☐Thyroid Condition
☐Tuberculosis	☐Ulcers	☐Varicose Veins	☐Other: _____	
			_____	
			_____	

Family History: Please note any family history of the following conditions and include relationship of relative to you:

☐Cancer: _____	☐Arthritis: _____	☐Spine or Back Disorder: _____
☐Diabetes: _____	☐Epilepsy: _____	☐Multiple Sclerosis: _____
☐Headache: _____	☐Heart Disease: _____	☐Mental Health Conditions: _____
☐High Blood Pressure: _____	☐Stroke: _____	☐Other: _____

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____