

MAGNOLIA SPECIFIC CHIROPRACTIC

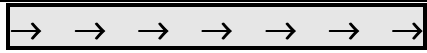
**Current Health Condition**

Unwanted Condition (Why you are here today?): \_\_\_\_\_

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

**PLEASE LABEL ON THE DIAGRAM, THE AREA OF DISCOMFORT**

Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

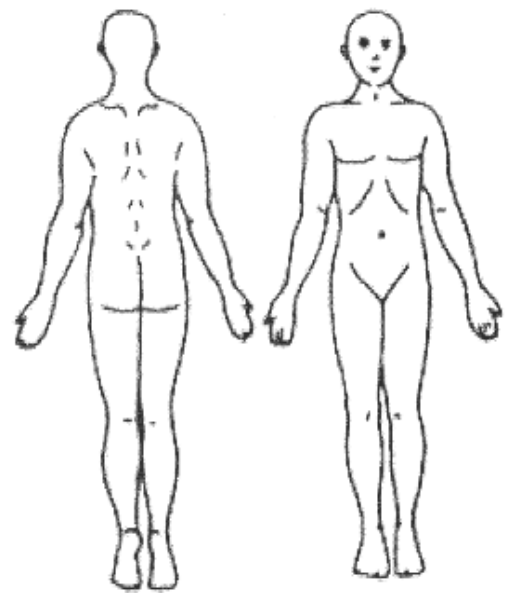
Is the Condition:  Auto Related  Job Related  Home Injury  
 Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am/pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?  
\_\_\_\_\_  
\_\_\_\_\_



**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as the problems can affect your overall course of care.

**PLEASE MAKE A CHECK MARK WITH THE FOLLOWING BOXES THAT APPLY TO YOU, OR MAKE CHECK MARK IN THE BOX SAYING, "I DENY having any of the symptoms or problems."**

**Constitutional:**  I DENY having or have had any of the symptoms or problems listed below.

- chills  fatigue  night sweats  weight loss
- daytime drowsiness  fever  weight gain

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness  change in vision  field cuts  photophobia
- blurred vision  double vision  glaucoma  tearing
- cataracts  eye pain  itching  wear glasses/contacts

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding  ear drainage  hearing loss  nosebleeds  sore throat
- dentures  ear pain  history of head injury  postnasal drip  tinnitus (ringing in ears)
- difficulty swallowing  fainting  hoarseness  rhinorrhea (runny nose)  TMJ problems
- discharge  frequent sore throats  loss of sense of smell  sinus infections
- dizziness  headaches  nasal congestion  snoring

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- asthma       coughing up blood       sputum production  
 cough       shortness of breath       wheezing

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort)       high blood pressure       shortness of breath with exertion or exercise  
 chest pain       low blood pressure       swelling of legs  
 claudication (leg pain/ache)       orthopnea (difficulty breathing lying down)       ulcers  
 heart murmur       palpitations       varicose veins  
 heart problems       paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- abdominal pain       diarrhea       indigestion       abnormal stool caliber       vomiting blood  
 belching       difficulty swallowing       jaundice       abnormal stool color  
 black - tarry stools       heartburn       nausea       abnormal stool consistency  
 constipation       hemorrhoids       rectal bleeding       vomiting

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control       cramps       irregular menstruation       vaginal bleeding  
 breast lumps/pain       frequent urination       pregnancy       vaginal discharge  
 burning urination       hormone therapy       urine retention

**Male:**  I DENY having any of the symptoms or problems listed below.

- burning urination       frequent urination       prostate problems  
 erectile dysfunction       hesitancy/ dribbling       urine retention

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- cold intolerance       excessive hunger       goiter       unusual hair growth  
 diabetes       excessive thirst       hair loss       voice changes  
 excessive appetite       abnormal frequency of urination       heat intolerance

**Skin:**  I DENY having any of the symptoms or problems listed below.

- changes in nail texture       hair loss       itching       skin lesions / ulcers  
 changes in skin color       hives       paresthesias       varicosities  
 hair growth       history of skin disorders       rash

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- dizziness       limb weakness       numbness       slurred speech       tremor  
 facial weakness       loss of consciousness       seizures       stress       unsteadiness of gait/ loss of balance  
 headache       loss of memory       sleep disturbance       strokes

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- anhedonia       behavioral change       convulsions       memory loss  
 anxiety       bi-polar disorder       depression       mood change  
 loss or change in appetite       confusion       insomnia

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- anaphalaxis       itching       chronic nasal congestion       sneezing  
 food intolerance       acute nasal congestion       rash

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- anemia       blood clotting       bruising easily       lymph node swelling  
 bleeding       blood transfusion       fatigue

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

**Previous Care for this Same Condition:**

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Was the treatment beneficial in resolving condition?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

**Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.**

- ADD
- atopic dermatitis (eczema)
- allergies/hayfever
- anemia
- asthma
- bedwetting
- cerebral palsy
- chicken pox
- crohn's/colitis
- depression
- diabetes
- ear infections
- fetal drug exposure
- food allergies (list below)
- headaches
- hepatitis
- HIV
- measles
- mumps
- psoriasis
- rash
- scoliosis
- seizure disorder
- sickle cell anemia
- spina bifida
- other:

**Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.**

- ADD
- alzheimers
- anemia
- arthritis
- asthma
- cancer
- cerebral palsy
- chicken pox
- crohn's/colitis
- CRPS (RSD)
- CVA (stroke)
- cystic kidney disease
- depression
- diabetes (insulin dep)
- diabetes (non insulin)
- eczema
- emphysema
- eye problems
- fibromyalgia
- heart disease
- hepatitis
- HIV
- hypertension
- influenzal pneumonia
- liver disease
- lung disease
- lupus erythema (discoïd)
- lupus erythema (systemic)
- multiple sclerosis
- parkinson's disease
- unspecified pleural effusion
- pneumonia
- psoriasis
- psychiatric problems
- scoliosis
- seizures
- shingles
- past history of similar symptoms
- STD's (unspecified)
- suicide attempt(s)
- thyroid problems
- vertigo
- other:

**Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition?  yes or  no.**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> angioplasty             | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy            | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section       | <input type="checkbox"/> dental surgery   | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsilectomy        |
| <input type="checkbox"/> carpal tunnel repair    | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other:              |
| <input type="checkbox"/> coronary artery bypass  | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           |  |

**Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> back injury      | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident        |
| <input type="checkbox"/> broken bones     | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild)     |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident                    | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe)    | <input type="checkbox"/> joint injury                           | <input type="checkbox"/> soft tissue injury (severe)   |
| <input type="checkbox"/> fracture         | <input type="checkbox"/> laceration (severe)                    | <input type="checkbox"/> other:                        |

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**Insurance Information:**

Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es))  Myself ONLY

Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?  Yes  No Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_ am/pm

Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

Carriers Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_

Claim #: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_