



# Health History

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle In. \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Referred by \_\_\_\_\_

Occupation: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_

**If your condition due to an auto or work related accident ask receptionist for an "Accident Form"**

If an accident is there a law suit ? \_\_\_\_\_ **If yes**, who are you who is law suit with? \_\_\_\_\_

### Head:

- Headaches
- Migraines
- Dizziness / Light-headed
- Lights bother eyes
- Loss of balance
- Loss of memory
- Loss of smell
- Loss of taste
- Loss of hearing
- Pain in ears
- Ringing in ears
- Grinding of teeth
- TMJ - Jaw pain / clicking

### Neck:

- Pain in neck
- Neck pain with movement
- Neck stiffness / tension
- Popping sounds in neck

### Arms & Hands:

- Pain in upper arm (R - L)
- Pain in forearm (R - L)
- Pain in hand (R - L)
- Pins & needles in arm (R - L)
- Pins & needles in hand (R - L)
- Cold hands
- Swollen joints in fingers
- Loss of grip strength

### Shoulders and Mid-back:

- Pain in shoulder joint (R - L)
- Pain across shoulder
- Cannot raise arm well
- Tension in shoulders
- Mid-back pain
- Pain between shoulder blades
- Muscle spasms

### Chest

- Chest pain
- Shortness of breath
- Pain around ribs
- Heart Palpitations

### Abdomen:

- Acid reflux/ Heart burn
- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea

### Low back:

- Low back pain
- Low back pain is worse when:
  - Working
  - Lifting
  - Standing
  - Sitting
  - Bending / coughing
- Pinched nerve in low back
- Muscle spasms / tension

### Hips, Legs, & Feet:

- Pain in buttocks (R - L)
- Pain in hip joint (R - L)
- Pain down leg (R - L)
- Knee pain (R - L)
- Pain in foot (R - L)
- Cramps in leg / feet (R - L)
- Pins & needles in leg (R - L)
- Pins & needles in foot (R - L)
- Swollen ankles / feet (R - L)
- Cold feet

### General:

- Nervousness
- Irritable
- Depressed
- Fatigue / Lack of energy
- Loss of sleep
- Loss of weight

### Woman Only:

- Menstrual pain
- Cramping
- Irregularity

### Men Only:

- Impotence
- Prostate problems

### Others:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



**For the previous symptoms checked please provide the following information:**

- a. **Date of initial onset** or **how long you have experienced this condition** (# of years, months, etc)?
- b. **Frequency** or **how often it occurs** (constant, daily, weekly, etc)?
- c. **Duration** or **length of time it usually lasts** (constant, minutes, hours, days, etc)?
- d. **Intensity of the pain from 0 - 10** ( 0 = no pain, 10 = worse pain imaginable )
- e. **Additional Comments**

Condition: \_\_\_\_\_

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

Condition: \_\_\_\_\_

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

Condition: \_\_\_\_\_

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

## Check any previously diagnosed condition

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Muscular Dystrophy     | <input type="checkbox"/> Autism                   |
| <input type="checkbox"/> Polio                    | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> ADD/ADHD                 |
| <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Convulsions            | <input type="checkbox"/> Herniated Disc           |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Bulging Disc             |
| <input type="checkbox"/> Heart Trouble            | <input type="checkbox"/> Concussion             | <input type="checkbox"/> Sciatica                 |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Digestive Disorders      |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Neuritis               | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> German Measles           | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Depression             | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Scarlet Fever            | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Guillan-Barre Syndrome |   |

### List any operations / surgeries and when performed

Surgery	Date
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

### List any medications you are presently taking and the condition you are taking them for:

Medication	Dosage	Condition
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____

- Is it your desire to eliminate/reduce medication you are taking?     Yes /  No
- Do you believe medication may be harmful to your health?     Yes /  No
- Are you interested in nutritional support?     Yes /  No
- Are you interested in fat loss?     Yes /  No
- Are you interested in personalized fitness training?     Yes /  No

## Lifestyle

### Exercise

How often do you get cardiovascular exercise?

- 4+ times per week    3 times per week    2 times per week    once a week    never

Select all cardiovascular exercise you do.

- Running    walking    stair master    swimming    cycling    aerobic    other

Select how often do you work out with weights.

- 3 times per week    2 times per week    once a week    every other week    never

List any contact sports you are involved in: \_\_\_\_\_

### Nutrition

How often do you eat nutritious food?:

- Every meal    two times daily    once a day    every other day    twice a week    once a week    never

How often do you drink coffee or caffeinated drinks

- 3+ per day    two times daily    once a day    every other day    twice a week    once a week    never

### Family History

How long have you been married? \_\_\_\_\_

Were you previously married? \_\_\_\_\_ How long? \_\_\_\_\_

Have you been divorced or separated? \_\_\_\_\_

How many children from current marriage? \_\_\_\_\_ List names and ages

Name	Age	Name	Age
1 _____	_____	4 _____	_____
2 _____	_____	5 _____	_____
3 _____	_____	6 _____	_____

How many children from previous marriage? \_\_\_\_\_ List names and ages

Name	Age	Name	Age
1 _____	_____	3 _____	_____
2 _____	_____	4 _____	_____

How would you rate your relationship with your spouse, 10=best ( 0 1 2 3 4 5 6 7 8 9 10 )

How would you rate your relationship with your children, 10=best ( 0 1 2 3 4 5 6 7 8 9 10 )

**Social**

Select the ways you take care of yourself:

- Church    Synagogue    Other Religious Instit.    Meditation    Yoga    Crafts    Outdoor Activ.
- Others: \_\_\_\_\_

**Specialists**

Specialty	Name	Address	Phone number
Medical Doctor	_____	_____	_____
Gynecologist	_____	_____	_____
Dentist	_____	_____	_____
Chiropractor	_____	_____	_____
Trainer	_____	_____	_____
Nutritionist	_____	_____	_____
Physical Therapist	_____	_____	_____

**Other Specialist**

Type	Name	Address	Phone number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date \_\_\_\_\_ Signature \_\_\_\_\_

Office: 847-619



**DIAGNOSTIC RADIOLOGY IN THIS OFFICE**

I, \_\_\_\_\_, authorize the performance of diagnostic x-ray examination of myself, which the above doctor may consider necessary or advisable in the course of my examination or treatment. I acknowledge that these X-rays are the sole property of Dr. Jeremy R. Barone and as such will be used exclusively for diagnostic purposes unique to the care of Dr. J. R. Barone.

Signed: \_\_\_\_\_

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

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**VERIFICATION THAT YOU ARE NOT PREGNANT**

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor has my permission to perform diagnostic x-ray examination. I have been advised that x-rays could be hazardous to an unborn child.

Date of last menstrual period: \_\_\_\_\_

Signed: \_\_\_\_\_

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

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**FOR PARENT OF MINOR (UNDER 18)**

I, \_\_\_\_\_, authorize the performance of diagnostic x-ray examination of my child or ward, which the above doctor may consider necessary or advisable in the course of examination and treatment. I acknowledge that these X-rays are the sole property of Dr. Jeremy R. Barone and as such will be used exclusively for diagnostic purposes unique to the care of Dr. J. R. Barone. The patient is a minor of \_\_\_\_\_ years of age.

Signed: \_\_\_\_\_

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

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's God-given ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or otherwise unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's God-given wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient Signature \_\_\_\_\_ Date : \_\_\_\_\_