CONFIDENTIAL PATIENT HISTORY

Today's Date: ____/____/____ E-mail:_____

Name: _____, Marital Status: □M □S
Last First MI

Address: _____
Street City State Zip

Date of Birth: ____/____/____, Age: _____, Sex: □M □F, Social Security #: _____

Please check which method and number you prefer to confirm appointments: □Text □Email

□Cell #:_____ □Home #:_____ □Work #:_____

Occupation: _____ Employer: _____

Name of closest Relative not residing with you: _____

Relationship: _____ Phone #: _____

Referred By: _____

HEALTH INFORMATION

Date of onset and description of your major complaint? _____

_____

What positions/activities make it worse?_____

_____

Is this condition interfering with your? □Work □Sleep □Daily Routine

Other doctors/treatment for this condition: _____

When/where was your last chiropractic treatment? _____

List surgical operations and year of procedure: _____

_____

Please list all drugs/medications you are taking: _____

_____

PAIN LEVEL: On a scale of 0-10, with 0 being pain free and 10 being agony, where would you rate yourself?

0 1 2 3 4 5 6 7 8 9 10

Treatment Preference: □Adjustment +ART/Graston □ART/Graston **ONLY**

□Adjustment **ONLY** □Doctor's Discretion

How old is your bed?_____, □Firm □Soft □Pillow-top

Sleeping position: □R-side □L-side □Back □Stomach □_____

Have you been in an auto accident? □No □Yes, When: _____

Please Describe: _____

Please describe any other personal injury or accident? _____

_____

Primary Care Physician: _____ Phone Number: _____

For Women: Are you Pregnant? □No □Yes, How long: _____

Birth control? □No □Yes, Name: _____

Do you**Smoke?** _____ packs per day, _____ years

Drink alcohol? _____drinks per week

Consume caffeine? _____cups per day

Exercise regularly? □Aerobics Class □Weight Training □Walk □Run □Bike □Swim

Frequency: _____

FAMILY MEDICAL HISTORY: Has any family member (parents, brothers, sisters, grandparents) had any health condition: _____

_____

I authorize Total Rehab to release any medical information, pertinent to my treatment, to my insurance company or physician. I clearly understand and agree that all fees for professional services rendered are charged directly to me and that I am personally responsible for immediate payment. I authorize the doctor and any other designated assistants of Total Rehab to perform diagnostic tests and administer treatment as necessary.

Patient's Signature: _____ Date:_____