Application for Treatment and Confidential Health History

Please fill out this application completely. Your answers will help us determine if chiropractic care can help you. If we ***do not sincerely believe your condition will respond satisfactorily, we will not accept your case.***

Name _____ Date ____/____/_____
Address _____ Apt. # _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell _____ Cell Carrier_____
Your Email _____
Birthday _____/_____/_____ Age _____ □ M □ F Marital Status _____
Spouse's Name _____ Number of Children: _____
Occupation _____
Is your condition due to an injury at work? □ Yes □ No If Yes, how did the injury happen?
_____
_____
Employer's Name _____
Address _____

Who referred you to our clinic? _____
Who is responsible for paying for your treatment? _____
Do you have health insurance? □ Yes □ No
If yes, with which insurance company? _____

Have you ever had chiropractic care? _____ If yes, date of last care: _____
For what condition were you treated? _____
_____
Name of your medical doctor: _____
Address _____

Please check the following conditions you have had <u>in the past</u>:

□ Alcoholism	□ Cold sores	□ Goiter	□ Miscarriage	□ Scarlet fever
□ Anemia	□ Diabetes	□ Gout	□ Multiple sclerosis	□ Stroke
□ Appendicitis	□ Diphtheria	□ Heart disease	□ Mumps	□ Tuberculosis
□ Arteriosclerosis	□ Eczema	□ Influenza	□ Pleurisy	□ Typhoid fever
□ Arthritis	□ Emphysema	□ Low back pain	□ Pneumonia	□ Ulcers
□ Cancer	□ Epilepsy	□ Malaria	□ Polio	□ Venereal Disease
□ Chorea	□ Fever blisters	□ Measles	□ Rheumatic fever	□ Whooping cough
□	□	□	□	□
□	□	□	□	□

Please check the appropriate box for any of the following symptoms which you have experienced. ***Only check the box if you have experienced the symptom; otherwise please leave it blank****. We need all the facts about your health history before we can evaluate* your condition. *THIS INFORMATION IS CONFIDENTIAL*

O = OCCASSIONAL **F = FREQUENT** **C = CONSTANT**

O F C

GENERAL

- ☐ ☐ ☐ Allergies
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headaches
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Weight loss
- ☐ ☐ ☐ Nervousness/depression
- ☐ ☐ ☐ Nerve Problems
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

MUSCLE & JOINT

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot problems
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Disc bulge
- ☐ ☐ ☐ Neck pain or stiffness
- ☐ ☐ ☐ Pain at shoulder blades
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Pain or numbness in:

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Tail bone

O F C

GASTRO-INTESTINAL

- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Distension of abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gall bladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ IBS or Crohn's Disease
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Stomach pain
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE, THROAT

- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noises
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum/teeth trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus problems
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heart beat
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swelling of ankles

RESPIRATORY

- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

SKIN

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dry skin
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions/rashes
- ☐ ☐ ☐ Varicose veins

GENITO-URINARY

- ☐ ☐ ☐ Bed wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control urination
- ☐ ☐ ☐ Kidney infection or stones
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate problems
- ☐ ☐ ☐ Blood in urine

FOR WOMEN ONLY

- ☐ ☐ ☐ Fibrotic breasts
- ☐ ☐ ☐ Menstrual cramps/backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐ Yes ☐ No

Last gynecological exam: (Date)

_____/_____/_____

Russell Health and Wellness Center, S.C. 477 Spring Road Elmhurst, IL 60126
(630) 530-0506

What health problem do you want us to evaluate? _____

How long have you had this health problem? _____ Have you had similar issues in the past? _____

_____

How did it happen? _____

What activities make your condition worse? _____

Are your symptoms, overall: □ Improving? □ Staying the same? □ Getting worse?

Are your symptoms: □ Constant □ Frequent □ They come and go

Is this condition interfering with your: □ Work □ Sleep □ Daily routine □ Recreation/Hobbies

□ Family or spouse relationship □ Other_____

How long has it been since you really felt good? _____

What activities has your lack of health caused you to give up or enjoy less?

_____

_____

If you could improve just <u>one</u> aspect of your health, what would it be?

_____

List previous diagnoses and treatments you have received for your present condition

_____

_____

_____

What do **<u>you</u>** believe is wrong with you?

_____

_____

What other health problems do you have:

_____

_____

_____

List any surgeries and dates:

_____

_____

_____

Drugs you take: □ Pain killers □ Muscle relaxers □ Heart pills □ Tranquilizers □ Antibiotics

□ Birth control pills □ Others _____

How often do you go to the dentist? □ Every six months □ Yearly □ Toothache or emergency only

How old is your mattress? _____ Is it □ Comfortable? □ Uncomfortable?

Do you wear: □ Heel lifts? □ Inner Soles? □ Arch supports?

Have you been in a car crash (even a "fender-bender") in the: □ Never □ Past year □ Past five years

□ Five to ten years ago □ Over ten years ago

Please describe the crash _____

_____

Have you ever had any mental or emotional disorders? □ Yes □ No If so, when? _____

Have others in your family had such disorders? □ Yes □ No If so, when? _____

FAMILY HEALTH INFORMATION *(Many health problems are hereditary. Thus, information about your family members will give us a better picture of your total health picture.)*

NAME	RELATIONSHIP to YOU	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	Please describe briefly
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve problem?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized other than for surgery?	☐	☐	

DO YOU:			
Take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Physical examination	☐	☐	☐	☐
Spinal examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Urine test	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Spinal Adjustment	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

List below all conditions for which you have been treated in the past <u>10 years</u>.

_____
_____
_____
_____
_____
_____

Who should we contact in case of an emergency? *(Name of relative or close friend* ***<u>NOT living with you</u>****)*:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone: home:_____ cell:_____