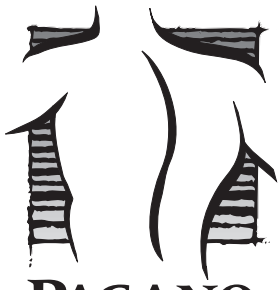


PAGANO
CHIROPRACTIC CENTER, P.C.

# Patient Health History

*Please answer to the best of your ability. If you have any questions, let us know.*

## Contact Information

Name _____ Date _____

Street address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Social Security Number (optional) _____

Which phone number is best to reach you at? ❍ Home ❍ Cell ❍ Work

## Personal Information

_____ Do you smoke? ❍ No ❍Yes Are you pregnant? ❍ No ❍Yes
Date of Birth

Marital Status: ❍ Single ❍ Married ❍ Domestic Partner ❍ Divorced ❍ Widowed Number of Children_____

Employer _____ Occupation _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

## Chiropractic History

How did you hear about us? _____

**Have you had chiropractic care before?** ❍ No ❍Yes

If yes, where? _____

## What Brings You Here Today?

Describe the problem/pain/location

When did the problem/pain start?

How long have you had the problem/pain?

**Have you had this pain before?** ❍ Yes ❍ No Is the problem getting ❍ Better ❍ Worse

**Is the pain:** ❍ Sharp ❍ Dull ❍ Stabbing ❍ Throbbing

**Does it affect daily activities?** ❍ Yes ❍ No If so, which ones? ❍ Sleep ❍ Driving ❍ Sitting ❍ Grooming ❍ Getting dressed ❍ Walking Other: _____

**Does it affect your work activities?** ❍ Yes ❍ No

If so, which ones? ❍ Computer ❍ Phone ❍ Lifting ❍ Bending ❍ Other: _____

**Does anything increase the problem/pain?** ❍ Yes ❍ No

If so, what? _____

**Does anything decrease the problem/pain?** ❍ Yes ❍ No

If so, what? _____

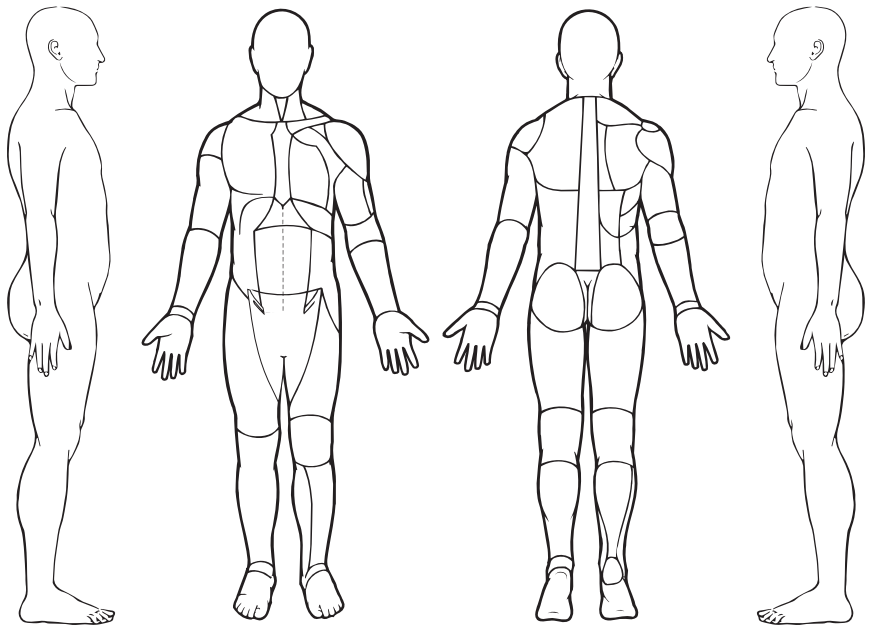
**Have you seen your primary care physician for this problem?** ❍ Yes ❍ No

Who is your primary physician? _____

**Have you been treated by another health care professional for this condition?** ❍ Yes ❍ No

If so, please select all that apply: ❍ Physical therapist ❍ Orthopedist ❍ Osteopath ❍ Homeopath ❍ Massage Therapist ❍ Acupuncturist ❍ Nutritionist ❍ Other: _____

**Please mark, with an 'X', where you have pain:**



**Is this problem/pain the result of:** ❍ On-the-job injury ❍ Auto accident ❍ Neither *(skip to medical history)*

Date of injury/accident: _____ Insurance company: _____

Attorney's name: _____ Attorney's address: _____

## Medical History

**Have you EVER had any falls, auto accidents, or injuries?** ❍ Yes ❍ No If yes, please describe:

Date:_____ Type of accident:_____

Injury:_____

Date:_____ Type of accident:_____

Injury:_____

Date:_____ Type of accident:_____

Injury:_____

**Have you EVER had x-rays?** ❍ Yes ❍ No

If yes: What body part(s)?_____

Where (location)?_____

**Have you EVER had an MRI?** ❍ Yes ❍ No

If yes: What body part(s)?_____

Where (location)?_____

**Have you EVER had surgery?** ❍ Yes ❍ No If yes, please describe:

Date:_____ Type of surgery:_____

Comments:_____

Date:_____ Type of surgery:_____

Comments:_____

Date:_____ Type of surgery:_____

Comments:_____

**Have you EVER been hospitalized**? ❍ Yes ❍ No If yes, please describe:

Date:_____ For:_____

Date:_____ For:_____

Date:_____ For:_____

**Are you presently taking medications, vitamins, or supplements?** ❍ Yes ❍ No If yes, list:

| **Name of Medication** | **Reason Taking** |
|---|---|
| | |
| | |
| | |

**Do you have a family history of the following:**

Diabetes? ❍ Yes ❍ No If yes, who? _____

Cancer? ❍ Yes ❍ No If yes, who? _____

Stroke? ❍ Yes ❍ No If yes, who? _____

High Blood Pressure? ❍ Yes ❍ No If yes, who? _____

**Please select any of the following you may have EVER experienced:**

❏ Neck Pain
❏ Neck Stiffness
❏ Neck Muscle Spasms
❏ Twitching of Face
❏ Grinding in Neck
❏ Headaches
❏ Migraines
❏ Sharp Head Pain
❏ Blurred Vision
❏ Ear Infection
❏ Sinus Trouble
❏ Asthma
❏ Allergies
❏ Loss of Smell
❏ Loss of Taste
❏ Loss of Balance
❏ Loss of Memory
❏ Dizzy/Vertigo
❏ Fainting
❏ Ringing in Ears
❏ Swollen Joints
❏ Painful Joints
❏ Mid Back Pain
❏ Mid Back Stiffness
❏ Mid Back Spasms
❏ Pain in Shoulders/Arms/Hands
❏ Tightness in Shoulders/Arms/Hands
❏ Pins and Needles in Shoulders/ Arms/Hands
❏ Numbness in Shoulders/Arms/Hands
❏ Stomach Trouble
❏ GI Issues
❏ Ulcers
❏ Breathing Trouble
❏ Shortness of Breath
❏ Indigestion
❏ Heart Trouble
❏ Heart Attack
❏ Heart Surgery
❏ Low Back Pain
❏ Low Back Stiffness
❏ Low Back Spasms
❏ Pain in Legs/Feet
❏ Tightness in Legs/Feet
❏ Pins and Needles in Legs/Feet
❏ Numbness in Legs/Feet
❏ Constipation
❏ Swollen Ankles
❏Intestinal Gas
❏ Kidney Problems
❏ Menstrual Cramps and Pain
❏ Menstrual Irregularity
❏ Cold Feet
❏ Irritability
❏ Fatigue
❏ Sleeping Problems
❏ Depression
❏ Diabetes
❏ Cancer
❏ High Blood Pressure
❏ Low Blood Pressure
❏ Nerves and Nervousness
❏ Thyroid Trouble

# Overflow Information

*Use this section to complete any information that didn't fit on Health History Page.*

I understand that I am directly and fully responsible to Pagano Chiropractic Center for all bills for services rendered.

I hereby authorize my insurance company to pay directly to Pagano Chiropractic Center the benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay in a current manner any balance, including co-pays and co-insurance, if said professional service charges are over and above this insurance payment.

Signature of Patient Date

Signature Authorizing Care Date