



PERSONAL HISTORY – PI

2050 Cincinnati-Dayton Road • Middletown, Ohio 45044
(513) 422-7776 • Fax: (513) 420-9075
7798 University Court, Suite A • West Chester, Ohio 45069
(513) 777-4577 • Fax: (513) 779-2824

Date: Social Security No.: E-Mail Address:
How Would You Like to Be Addressed By Our Staff:

Name: Address: City: State: Zip:

Birth Date: Age: Sex: M F No. of Children:

Home Phone #: Cell Phone # (if applicable):

Work Phone #: Dept. or Ext.: Pager #(if applicable):

Business/Employer: Type of Work:

Address: City: State: Zip:

Check One: Married Single Widowed Separated Divorced

Nearest Relative (not living at home): Phone:

Spouse's Name: Spouse's Birth Date: Spouse's Soc. Sec. No.:

Spouse's Employer: Occupation: Phone #:

Address: City/State/Zip:

IF THE PATIENT IS A MINOR:

Father's Name: Social Security Number: Birth Date:

Address (if different than patient's):

Employer: Address: Work Phone:

Mother's Name: Social Security Number: Birth Date:

Address (if different than patient's):

Employer: Address: Work Phone:

CURRENT HEALTH CONDITION

Current Complaints/Reason for Visit:

Other Doctors Seen for This Condition:

When Did This Condition Begin?: If Disabled from Work (Dates) Start: To:

Family Physician: Address:

City/State/Zip: Phone:

Medications You Now Take: Nerve Pills Birth Control Blood Pressure Medicine Insulin
(Pain Killers/Muscle Relaxers Other:

Medications You Are ALLERGIC to:

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Hysterectomy
Other:

Major Accidents or Falls:

Hospitalizations:

Previous Chiropractic Care: None or Doctor's Name & Approximate Dates:

Have you been treated for any health condition in the last year? Y N Explain:

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care Corrective Care Comprehensive Care Check here if you want the doctor to select the type of care appropriate for your condition.

I plan to pay for my visit today by:

- Cash
 Check
 Visa/MasterCard/Discover

My case may involve:

- Medicaid:** Allows 30 visits per year. Show the staff your card.
- Private Insurance:** Private Insurance Company Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Name of Insured: _____
Other Insurance Name: _____
- Workers' Compensation:** If your care is related to Workers' Compensation, you must obtain written consent from your employer allowing you to receive care at our office. Fill out Work Injury Questionnaire.
- Auto Accident:** Verification must be made through the insurance adjuster and/or attorney. Please complete Auto Accident Questionnaire
- Medicare:** Medicare may help with a portion of your visits. We do accept assignment for Medicare allowed charges. Evaluation is required by Medicare, but Medicare does not pay for these charges.
- Lawsuit:** You are responsible for payment of your bill as you receive care. Notify your attorney that you are under our care.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. *However, I clearly understand and agree, that all services rendered me are charged directly to me, and that I am personally responsible for payment. Any charges not paid in 60 days by the insurance company will be paid with a personal payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that x-rays are the property of this office and copies of x-rays and/or files are available at the patient's request. I also agree to allow Chiropractic Associates, Incorporated to research my credit history if it is deemed necessary.*

Patient Signature X _____ **Date** _____

Guardian or Spouse's Signature Authorizing Care _____ **Date** _____



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PATIENT MEDICAL HISTORY FORM

Name: _____ Age: _____ Sex: M / F Date: _____

ALLERGIES: Medications: _____
 Environmental: _____
 Food: _____

Please check YES if YOU currently have or have ever had any of the following:

	<u>YES</u>	<u>WHEN DIAGNOSED</u>		<u>CURRENT TREATMENT</u>
<u>LUNGS:</u>				
Asthma/Emphysema	<input type="checkbox"/>	_____		_____
Tuberculosis	<input type="checkbox"/>	_____		_____
Lung Cancer	<input type="checkbox"/>	_____		_____
Sarcoidosis	<input type="checkbox"/>	_____		_____
Other: _____	<input type="checkbox"/>	_____		_____
Surgery: _____				_____
<u>HEART:</u>				
Congestive Heart Failure	<input type="checkbox"/>	_____		_____
Heart Murmur	<input type="checkbox"/>	_____		_____
Heart Attack(s)	<input type="checkbox"/>	_____		_____
Irregular/Fast Heartbeat	<input type="checkbox"/>	_____		_____
Chest Pain/Angina	<input type="checkbox"/>	_____		_____
Elevated Cholesterol	<input type="checkbox"/>	_____		_____
Pacemaker	<input type="checkbox"/>	_____		_____
Other: _____	<input type="checkbox"/>	_____		_____
Surgery: _____				_____
<u>BLOOD PRESSURE:</u>				
High Blood Pressure	<input type="checkbox"/>	_____		_____
Low Blood Pressure	<input type="checkbox"/>	_____		_____
Other: _____	<input type="checkbox"/>	_____		_____
<u>BLOOD:</u>				
Anemia	<input type="checkbox"/>	_____		_____
Sickle Cell Disease	<input type="checkbox"/>	_____		_____
Bleeding Disorder	<input type="checkbox"/>	_____		_____
Leukemia	<input type="checkbox"/>	_____		_____
Blood Cancer	<input type="checkbox"/>	_____		_____
Other: _____	<input type="checkbox"/>	_____		_____
<u>ENDOCRINE:</u>				
Diabetes	<input type="checkbox"/>	_____		_____
Cancer-Pancreas/Adrenal Glands	<input type="checkbox"/>	_____		_____
Thyroid Problems	<input type="checkbox"/>	_____		_____
Cancer-Thyroid	<input type="checkbox"/>	_____		_____
Other: _____	<input type="checkbox"/>	_____		_____
Surgery: _____				_____
<u>GASTROINTESTINAL:</u>				
Jaundice/Hepatitis	<input type="checkbox"/>	_____		_____
Ulcers/Bleeding	<input type="checkbox"/>	_____		_____
Hiatal Hernia	<input type="checkbox"/>	_____		_____
Cancer-Liver/Colon/Stomach	<input type="checkbox"/>	_____		_____
Other: _____	<input type="checkbox"/>	_____		_____
Surgery: _____				_____

	<u>YES</u>	<u>WHEN DIAGNOSED</u>	<u>CURRENT TREATMENT</u>
<u>GENITOURINARY:</u>			
Kidney Disease	<input type="checkbox"/>	_____	_____
Cancer-Prostate	<input type="checkbox"/>	_____	_____
Cancer-Cervical/Uterine/ Ovarian/Breast	<input type="checkbox"/>	_____	_____
Other: _____	<input type="checkbox"/>	_____	_____
Pregnant Now?	<input type="checkbox"/>	Due Date: _____	_____
Previous Pregnancy(ies)	<input type="checkbox"/>	# _____	Type of Delivery(ies): _____
Date of Last Menstrual Period: _____			
Surgery: _____			

<u>MUSCULOSKELETAL:</u>			
Degenerative Arthritis	<input type="checkbox"/>	_____	_____
Rheumatoid Arthritis	<input type="checkbox"/>	_____	_____
Lupus	<input type="checkbox"/>	_____	_____
Cancer-Bone/Muscle	<input type="checkbox"/>	_____	_____
Skin Problems	<input type="checkbox"/>	_____	_____
Other: _____	<input type="checkbox"/>	_____	_____
Surgery: _____			

		<u>WHAT</u>	<u>WHEN</u>
Fractures/Broken Bones	<input type="checkbox"/>	_____	_____
Joint Replacements	<input type="checkbox"/>	_____	_____

	<u>YES</u>	<u>WHEN DIAGNOSED</u>	<u>CURRENT TREATMENT</u>
<u>NERVOUS SYSTEM:</u>			
Fainting/Dizziness	<input type="checkbox"/>	_____	_____
Migraine Headaches	<input type="checkbox"/>	_____	_____
Convulsions/Epilepsy/Seizures	<input type="checkbox"/>	_____	_____
Stroke/Paralysis	<input type="checkbox"/>	_____	_____
Numbness/Tingling	<input type="checkbox"/>	_____	_____
Cancer-Brain/Spinal Cord	<input type="checkbox"/>	_____	_____
Alzheimer's	<input type="checkbox"/>	_____	_____
Vertebrae/Disc	<input type="checkbox"/>	_____	_____
Head Injury	<input type="checkbox"/>	_____	_____
Multiple Sclerosis	<input type="checkbox"/>	_____	_____
Other: _____	<input type="checkbox"/>	_____	_____
Surgery: _____			

<u>EYES-EARS-NOSE-THROAT:</u>			
Glaucoma	<input type="checkbox"/>	_____	_____
Cataracts	<input type="checkbox"/>	_____	_____
Lazy Eye/Muscle Problems	<input type="checkbox"/>	_____	_____
Retinal Problems	<input type="checkbox"/>	_____	_____
Hearing Problems	<input type="checkbox"/>	_____	_____
Tinnitus	<input type="checkbox"/>	_____	_____
Sinus Problems	<input type="checkbox"/>	_____	_____
Jaw Pain	<input type="checkbox"/>	_____	_____
Jaw Clicking/Popping	<input type="checkbox"/>	_____	_____
Other: _____	<input type="checkbox"/>	_____	_____
Surgery: _____			

<u>SOCIAL HISTORY & HABITS:</u>			
Do you drink alcohol?	<input type="checkbox"/>	<u>YES</u>	<input type="checkbox"/> # _____ drinks per day / week / month
Do you smoke cigarettes?	<input type="checkbox"/>	<u>NO</u>	<input type="checkbox"/> # _____ packs per day Other: _____
Do you drink caffeinated beverages?	<input type="checkbox"/>		<input type="checkbox"/> # _____ beverages per day
How many glasses of water do you drink per day?			# _____ glasses per day
How many hours of sleep do you get per day?			# _____ hours per day
How many meals do you eat per day?			# _____ meals per day
SPECIAL DIET? _____			
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>	What kind? _____

Please check YES if a member of your family currently has or has ever had any of the following:

FAMILY HISTORY:

	YES	Relationship
Heart Disease	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____
Cancer (TYPE: _____)	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	_____
Eye Problems (TYPE: _____)	<input type="checkbox"/>	_____
Ear Problems (TYPE: _____)	<input type="checkbox"/>	_____

Please list any additional surgical procedures with dates that are not listed above:

Please list any other hospitalizations with dates that are not listed above:

Please list all prescribed medications, over-the-counter medications and supplements you currently take:
(Or attach list)

<u>Name:</u>	<u>Taken For What Condition:</u>	<u>Dosage:</u>	<u>Frequency:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have answered the above questions to the best of my knowledge.

Patient's Signature

Date

Reviewed by:

Physician's Signature

Date

FOR PHYSICIANS' USE:

History Reviewed: _____ Date: _____ Interval Changes: YES ____ NO ____
If changes, please note: _____
Initials: _____

History Reviewed: _____ Date: _____ Interval Changes: YES ____ NO ____
If changes, please note: _____
Initials: _____

History Reviewed: _____ Date: _____ Interval Changes: YES ____ NO ____
If changes, please note: _____
Initials: _____