Confidential Patient Information

Today's date:_____ Name:_____

What you like to be called:_____ Age: ___ Home phone #:_____

Work phone #:_____ Cell phone #: _____

Address:_____

_____Birth date:_____

Who referred you to this office?_____ Email Address:_____

Insurance Company and Plan (if any):_____

Profession and/or Main Life Activity:_____

Employer (including address):_____

Previous occupations/activities: _____

Emergency Contact: Name:_____ Their relationship to you:_____

Their home and work phone numbers:_____

Informed Consent: I know that I have the right to ask any question I need to about the procedures offered by Dr. Russell and that I can refuse any treatment he offers to perform. Dr. Russell and I share the responsibility of my understanding what his diagnosis of my condition is and how he intends to help me with said condition(s). By engaging in this care relationship with Dr. Russell, I agree to work in cooperation with him to educate myself about my condition and make responsible, informed choices about my healthcare. I understand that I always have the right and responsibility to know what any practitioner believes my health status to be; the manner in which that practitioner intends to treat me for any condition(s) I may have; and the alternatives available to me, before I consent to receiving any treatment from that practitioner. The neuromusculoskeletal healthcare offered by Dr. Russell may not be what I need; so I understand that Dr. Russell may need to refer me to another practitioner, either to work together with him or in his place. Finding the best way to assist my healing process is the number one consideration for both of us.

Signature:_____ Date:_____

Main Complaint

What is your major complaint today?_____

_____

How long have you had this problem?_____

Have you had this problem before? Yes__ No__ When and how often?_____

What helps this condition?_____

What makes it worse? _____

Is it getting worse? Yes ___ No ___ Constant ___ Comes and Goes _____

Does this condition interfere with your work?____ Sleep?____ Daily routine?_____ Other _____

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

Has anyone else treated you for this condition? (If yes, explain):_____

_____

Do you have any other complaints/symptoms today?_____

_____

History of Medical Care

Have you had previous chiropractic care? Yes___ No____ If so, with whom and for what reason?

_____

_____

List any surgeries you have had and the dates of surgery:_____

_____

_____

Have you ever been advised to have a surgical procedure which has not been performed? (Please explain)

_____

Date of last physical exam:_____

Name and phone number of doctor who examined you:_____

Drugs you now take (prescription or non-):

___ Diet Pills	___ Anti-depressants	___ Thyroid meds
___ Pain Relievers	___ Tranquilizers	___ Hormones (including steroids or estrogen)
___ Birth control	___ Stimulants	___ Muscle relaxants
___ Insulin	___ Blood thinners	___ Sleeping pills
___ Anti-psychotics	___ Antibiotics	

___ Other (please list):_____

Illnesses

Please check any condition you have ever had.

___ High/low blood pressure	___ Pleurisy	___ Heart problems/murmur
___ Ulcers/Colitis/bowel problems	___ Arthritis/Rheumatism	___ Bone/joint disease
___ Neuritis/neuralgia	___ Bursitis/sciatica/lumbago	___ Polio
___ Kidney infection/stones	___ Sexually transmitted disease	___ Gall bladder problems
___ Anemia	___ Jaundice/Hepatitis	___ Bladder infections
___ Epilepsy (seizures/fits)	___ Migraine Headaches	___ Diabetes
___ Chronic Fatigue Syndrome	___ Cancer (type?_____)	___ Psychiatric illness
___ Depression	___ Asthma	___ Emphysema
___ Thyroid problems/goiter	___ Hives/Eczema	___ Herpes (genital or oral)
___ Shingles (herpes zoster)	___ Rectal problems	___ HIV infection/AIDS
___ Gout	___ Hernia	___ Multiple Sclerosis
___ Prostate problems	___ Stroke	___ Artificial bones/joints
___ Chemical/drug dependency	___ Lyme Disease	___ Suicidal thoughts
___Scoliosis	___ Anxiety	___ Fibromyalgia
___Scleroderma	___ Autoimmune Disorder	

Do you have any allergies? (List)_____

Have you ever been in a motor vehicle accident? ____ past year ___ past 5 years ___ over 5 years

Describe _____

_____

Have you ever had any ___ broken bones ___ sprains ___ dislocations ___ concussion/head injury

Have you ever been knocked unconscious?_____

Do you have any other concerns or history the doctor should be aware of? _____

_____

_____

Check any problem you have had in the last year.

___ coughed up blood
___ night sweats
___ vomiting blood
___ anorexia/bulimia
___ excessive thirst
___ pain when urinating
___ blood in urine
___ frequent urination
___ chest pain/angina
___ swelling of hands/feet
___ braces (on your teeth)
___ trembling/twitching
___ TMJ/jaw pain
___ grinding your teeth
___ frequent/severe headache
___ fainting/dizziness
___ earaches/ear discharge
___ recurrent nosebleed
___ Sinus trouble
___ Persistent hoarseness
___ difficulty swallowing
___ leg cramps at night
___ growth in neck or throat
___ brittle/weak nails
___ change in hair/skin texture
___ cold hands/feet

___ chronic/persistent cough
___ difficulty breathing when lying flat with no pillows
___ shortness of breath on climbing one flight of stairs
___ purple or blue lips or fingers
___ recurrent stomach pain, nausea or cramping
___ heartburn/excessive belching and gas
___ change in color/texture of your stool (bowel movement)
___ difficulty stopping or starting flow of urine
___ waking up frequently to urinate
___ loss of urine on coughing, sneezing, laughing
___ sensation of incomplete emptying of bladder
___ numbness, tingling or weakness in hands
___ swelling, redness or heat in a joint
___ dentures, false teeth, other dental problems
___ changes or problems with vision
___ pain behind your eyes
___ wear glasses (last checkup date? _____)
___ difficulty hearing/ringing in ears
___ hay fever
___ loss of sense of smell or taste
___ enlarged glands
___ varicose veins
___ unusual tiredness
___ dry skin
___ easy bruising or bleeding
___ sensitivity to hot and cold

For women:

When was your last pelvic exam? _____ Findings? _____

When was you last PAP test? _____ Findings?_____

When was your last mammogram?_____ Findings?_____

Do you perform a self breast exam? _____ How often? _____ If not, why not?_____

_____

Is your period regular? ___ Do you get PMS? _____

Are you peri-menopausal? ___ Post-menopausal? ____

Are you pregnant?_____

Have you ever been pregnant? ___ If so:

Have you ever had a Caesarean section? _____

Have you ever had an abortion or miscarriage? _____

Family History:

Has anyone in your family ever had these problems? If so, what is their relationship to you?

Cancer _____ Tuberculosis _____

Heart trouble _____ High blood pressure _____

Stroke _____ Epilepsy _____

Mental illness _____ Suicide or attempt _____

Osteoporosis _____ Alcoholism _____

Asthma _____ Scoliosis _____

Diabetes _____ Other major illness _____

Family health:

	(If living)		(If deceased)	
	Age	health status?	Age at death	Cause
Mother	___	_____	___	_____
Father	___	_____	___	_____
Brothers and Sisters:				
Name:				
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
Spouse or Partner:				
Name:				
_____	___	_____	___	_____
Children:				
Name:				
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____

Social History/Lifestyle:

Living situation: ___ alone ___ with partner(s) ___ with family ____ with others

If you have children, do they live with you? ____ Do you have pets? What kind? _____

Do you have a religious or spiritual practice of any kind? (Include prayer/meditation, yoga, etc.)

If so, describe it briefly:_____

In the past year, what have been your major stresses?_____

_____

In the past year, have you experienced any major change in:

___ sleep

___ appetite ___ general energy level ___ weight ___ level of sexual desire/activity

___ primary relationships ___ memory/concentration ___ work satisfaction

___ income/ability to pay bills ___ level of involvement with others

Do you have recurrent troublesome thoughts or feelings? _____

Have you recently lost someone you love? _____

Do you often have feelings of helplessness/hopelessness? _____

How would you describe your mood in general?

___ Happy ___ Content ___ Depressed ___ Anxious ___ Elated

Do you smoke? ___ Did you ever smoke? ____ How many packs a day/week? _____

How old were you when you started smoking? ___ When did you stop (if applicable)? _____

What is your weekly consumption of alcohol? _____

Do you consider yourself a social drinker? ____ a habitual drinker? ___

Is alcohol an integral part of your lifestyle?____ Have you ever felt the need to cut down on your drinking? ___

Have you ever felt annoyed by criticism of your drinking? ___ Have you ever felt guilty about your drinking? ___

Do you use recreational drugs? ____ Have you ever tried to cut down your use of them? ____

How old is your mattress?:_____ Is it comfortable?_____

What type and number of pillows do you use?_____

What position(s) do you sleep in (include position of pillows and arms!)_____

_____

Do you wear: heel lifts _____ Inner soles ____ Orthotics ____ Did you: buy them ___

get them through a doctor ____ Do you ever wear shoes with heels higher than 1 inch?_____

Do you exercise?_____ Describe the physical activities you do and how often you do them:

_____

_____

Diet

What are your two favorite foods?_____

Check any food that you eat at least twice a day:

___ Red meat, fish, poultry, or eggs
___ White bread, potatoes, or white rice
___ Dairy products (milk, cheese, yogurt, etc.)
___ Home-cooked food
___ Fruit
___ Green vegetables (including salad)
___ tofu or beans
___ Whole grains or whole grain bread
___ Potato chips, pretzels, or corn chips
___ Restaurant or fast food
___ Sugar (include sugar in drinks)

How much water do you drink daily (no. of 8 oz. glasses, including seltzer/club soda)? _____

How much coffee do you drink daily (no. of 6 oz. cups)? _____

How much soda do you drink (10 - 12 oz. cans, not counting seltzer/club soda)? _____

Vitamins/Supplements you now take:_____

_____

Which of the following would you be willing to do to resolve the major complaint that brings you here today?

___ change jobs ___ perform exercises at home ___ move to a different state/environment

___ change home environment ___ make changes in my primary relationships

___ commit to a six-month treatment and exercise regimen ___ give up favorite leisure activity

___ give up favorite food ___ quit smoking or drinking alcohol or coffee

I understand the above questions and guarantee that this form is completed correctly to the best of my knowledge. I know that Dr. Russell will rely on this information as part of his evaluation and treatment plan for me and I understand that it is my responsibility to inform this office of any changes in my health status.

Patient's signature:_____ Date:_____

Guardian's signature:_____ Date:_____