STALLINGS
CHIROPRACTIC CENTER, LLP

820 Chuck Gray Court
Owensboro, Kentucky 42303
(270) 685-5100 • Fax (270) 683-3100

CONFIDENTIAL PATIENT DATA

Dear Patient: Please complete this questionnaire. If you need any assistance, please ask the receptionist. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

(PLEASE PRINT)

Name _____ Date _____
(last) (first) (middle)

Address _____ Home Phone _____

City _____ State _____ Zip _____

_____ ☐M ☐F Marital Status ☐M ☐S ☐W ☐D ☐Sep. Number of Children _____
Age Ht. Wt. Date of Birth Sex

Your Occupation or Profession _____ Cell Phone _____

Employed by _____ Business Phone _____

Name of Spouse or Parent _____ Cell Phone _____

Employed by _____ Business Phone _____

Referred by ☐ Family/Friend Who? _____ ☐ Doctor Who? _____

☐Newspaper ☐Yellow Pages ☐Saw clinic sign ☐Mail ☐Other _____

Have you had chiropractic care before? ☐Yes ☐No Date of last adjustment _____ Where? _____

Do you have health insurance? _____ What Company? _____

Social Security No. _____ Who is responsible for account? _____

How will charges be paid? ☐Check ☐Cash ☐Credit Card ☐Health Insurance ☐Auto Insurance ☐Worker's Comp

Email Address _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL
FREQUENT

GENERAL
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints
- ☐ ☐ Pain, numbness or cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knee

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digestion
- ☐ ☐ Distension of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE &THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat
- ☐ ☐ Swelling

PSYCHIATRIC
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Other conditions
- ☐ ☐ Hospitalization

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

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge

Pregnant ☐ Yes ☐ No
Date of last period _____
Previous miscarriages ☐ Yes ☐ No

DATE OF LAST: (APPROX.)
- _____ Physical examination
- _____ Blood test
- _____ Chest x-ray
- _____ Spinal x-ray
- _____ Dental x-ray
- _____ Urine test

NONE LIGHT MODERATE HEAVY
- ☐ ☐ ☐ ☐Alcohol
- ☐ ☐ ☐ ☐Coffee
- ☐ ☐ ☐ ☐Tobacco
- ☐ ☐ ☐ ☐Drugs
- ☐ ☐ ☐ ☐Exercise
- ☐ ☐ ☐ ☐Soft drinks

HAVE YOU EVER:
- ☐ Been in an accident? ☐ Auto ☐ Job ☐ Other
- ☐ Been knocked unconscious?
- ☐ Used a crutch or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Had surgery? (list on back)*

CASE HISTORY

(Please complete other side)

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PLEASE PRINT

Please list any surgeries you have had and give dates _____

Please list any prescription or over-the-counter drugs you are taking _____

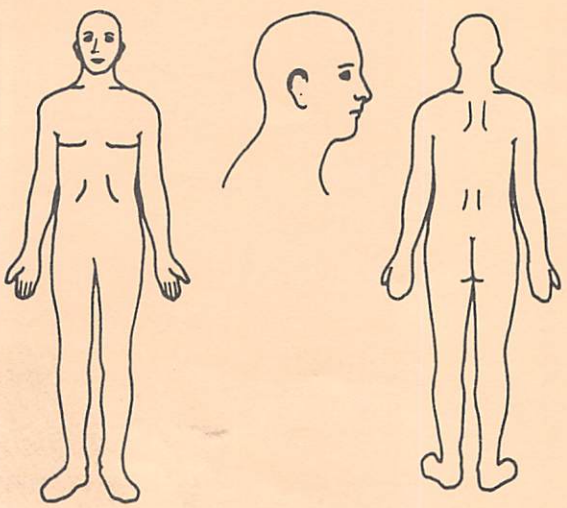
Please list any supplements you are taking _____

Do you have any allergies? ☐Yes ☐No To what? _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ AIDS/ARC	☐ Cancer	☐ Epilepsy	☐ Hepatitis	☐ Muscular Dystrophy	☐ Stroke
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease

Please mark your areas of pain on the figures below.



Describe major complaints and symptoms - Please rate your symptoms (1-10, with 1 being least serious) - _____

Date you first noticed symptoms: _____

Has this happened before? _____ When? _____

Symptoms developed from: ☐Job Related Injury ☐Auto Accident ☐Other Accident ☐Illness ☐Unknown Cause ☐Gradual Onset ☐Other

Date Occurred: _____

Symptoms have presisted for #_____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

Symptoms/complaints ☐Come & Go ☐Are Constant Symptoms are worse in the ☐Morning ☐Afternoon ☐Night

If you were to guess, what do you think is causing your complaints?

_____

Name and location of doctors previously seen for present condition(s):

_____

_____

Please check the following activities that AGGRAVATE your condition:

☐Bending ☐Reaching ☐Straining at stool ☐Coughing ☐Sitting ☐Turning Head ☐Lifting ☐Sneezing ☐Walking ☐Lying Down ☐Standing

Please check the following activities that **RELIEVE** your condition:

☐Bending ☐Sitting ☐Lifting ☐Standing ☐Lying Down ☐Turning Head ☐Reaching ☐Walking

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Every health care profession including Chiropractic has potentially serious risks associated with diagnostic and treatment procedures. If you have any question at all or are concerned in any way about these risks, please ask us. We have written information, video information and consultations at no charge, regarding any risks inherent with our diagnostic and treatment procedures. By signing here you agree that you have read and understood the above statement.

_____ _____ _____
Signature Date Witness

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

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