McCARVER FAMILY CHIROPRACTIC, P.C.

PERSONAL HEALTH HISTORY

WELCOME TO OUR FAMILY!

Name _____Date _____ Patient #_____
Address_____ City/State/Zip_____
Date Of Birth _____ Social Security Number _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Marital Status S M D W E-mail address _____Can we email health info: Y N
Spouse's Name & Age _____ Spouse's Occupation_____
Children's Names & Ages _____
_____
Name of Employer _____ Occupation_____
Hobbies_____
Who Referred You _____
Name of Parent or Guardian_____

Name Of Previous Chiropractors _____ When was your last visit? _____
For how long were you receiving Chiropractic adjustments? _____

Reason for coming in _____

What accidents have you had (ex. Bicycle, car, motorcycle, sports, slips/falls) at work or at home (include dates)
_____
_____
Were you ever knocked unconscious? _____
What fractures or broken bones have you had? (include dates) _____
_____

SURGERY:

What major surgery have you had? (include dates) _____
_____
What minor surgery have you had? (tonsillectomy, appendectomy, wart/cyst removal, dental extraction) _____
_____

MEDICATION:

Present Prescription Drugs	Past Prescription Drugs	Over-The-Counter Drugs (aspirin, cold tablets, cough syrup)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

THERAPY:

Are you presently under any therapeutic care? (what type) _____
What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc., include dates) _____
_____

YOUR BIRTH RECORD:

Type of birth (Vaginal, Cesarean, etc.) _____
Any complications during your mothers pregnancy or during your birth?_____
Any complications after your birth?_____

CURRENT HEALTH:

How would you describe your current health? _____Your family's health? _____
Describe your: Vision _____ Hearing _____ Coordination _____
Do your use any of the following: Tobacco Alcohol coffee/tea regular cola diet cola milk
Level of stress in your life: mild moderate extreme 1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following: **Bottled Drinking Water:** ( ) No ( ) Yes
Vitamins: ( ) No ( ) Yes **Health Food Products** (organic products, etc.) ( ) No ( ) Yes

FINANCIAL INFORMATION:

Who is responsible for this account? _____
What method of payment will you be using? **Ins Cash Check** MC/Visa/Discover/AmEx Other _____
Name of Insurance Company _____ Policy # _____
Insured's Date of Birth _____ Do you have secondary insurance? ( ) Yes ( ) No
Name of Insurance Company _____ Policy # _____

Please check any of the following that give you difficulty or you have had recently

__**Headaches 784.0**	__Fainting 780.2	__Shortness of breath 786.0	__Asthma 493.9
__Shooting head pains 784.0	__Loss of balance 781.2	__Menstrual Cramp/Pain 625	__Constipation 564.0
__**Sinus Trouble 473.9**	__Ringing in the ears 388.3	__Heart attack 410.9	__Kidney trouble 593.9
__**Neck Pain 723.1**	__Blurred vision 368.0	__Low blood pressure 458.9	__Loss of taste 781.1
__Allergies 995.3	__Lights bother eyes 368.13	__High blood pressure 401.9	__Sore throat 462
__Muscle Spasms in neck 781	__Stomach trouble 789	__Anemia 285.9	__Diabetes 250.0
__Grinding in neck 719.4	__Nerves/Nervousness 799.2	__Menstrual Irregularity 626	__Thyroid trouble 246.9
__Shoulder/arm tight 728.85	__Inner Tension 799.2	__Sleeping Problems 780.5	__Painful joints 719.4
__Shoulder/arm pain 719.4	__Irritability 799.2	__Pain in legs/feet 719.4	__Swollen joints 719.0
__Pins & Needles in arms 782	__Indigestion 536.8	__**Hip Pain 719.45**	__Ulcers 534.9
__Ear Infection	__**Numbness in arms/hands 782**	__**Low back pain 724.2**	__Arthritis 716.96
__Gall bladder trouble 579	__Swollen ankles 782.3	__Cancer	__Earache
__Mid-back pain 724.1	__Cold hands 782	__Loss of Smell 781.1	__Cold feet 782
__**Fatigue 780.7**	__**Numbness in legs/feet 782**	__Intestinal Gas 787.3	__Facial twitch 781
__**Depression 311.0**	__Tonsillitis 784	__Hay Fever 477.8	__Loss of Memory
__Dizziness 780.4	__Prostate Trouble 601.4	__Hernia 550.1	__Facial pain 784.0
__Spinal curvature 737.43	__Bed wetting 788.3	__Stroke 436.0	__Jaw pain (TMJ) 525.9
__Seizures	__Other _____		

PEDIATRIC PATIENTS ONLY:

Authorization for Care of a Minor:

I hereby agree to allow McCarver Family Chiropractic, P.C. and its doctors to administer care to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by McCarver Family Chiropractic, P.C..

Name of Child?Minor:_____

Signature of Parent/Guardian:_____ Date:_____