

# Comprehensive Health and Chiropractic Centre Family Practice

555 South Rancho Santa Fe Road, Ste. 200  
San Marcos, CA 92069

(760) 736-0286 • (760) 736-3113



<b>PERSONAL DATA</b>	<p>Date: _____ Chart Number: _____</p> <p>Home phone: _____ Cell phone: _____</p> <p>Last Name: _____ First Name: _____ M.I. _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____</p> <p>Please check one: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> <p>SSN: _____ / _____ / _____ Your Driver's Lic.#: _____</p> <p>Are you/have you been disabled from work? _____</p> <p>E-mail address: _____</p> <p>We call you before your appointment to remind you of the appointment. Would you like to be reminded by: 1) Telephone; 2) Email; or 3) Both (please circle your choice)</p> <p>Would you like to receive our newsletter by email? 1) Yes; 2) No (please circle your choice)</p>
<b>BUSINESS DATA</b>	<p>Business phone: _____</p> <p>Business/Employer: _____</p> <p>Type of work: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
<b>SPOUSE DATA</b>	<p>Spouse's name: _____ Social Security # _____</p> <p>Business phone: _____</p> <p>Business/Employer: _____</p> <p>Type of work: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
<b>EMERGENCY CONTACT</b>	<p>Name and address of nearest relative not living with you:</p> <p>Name: _____ Relationship: _____</p> <p>Address: _____ Phone#: _____</p>
<b>REFERRAL</b>	<p>Referred to this office by: _____</p>

# Comprehensive Health and Chiropractic Centre

Dr. Kimberly Rollheiser

## INSURANCE

### 1 RESPONSIBLE PARTY

Name of person responsible for this account? \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work phone# \_\_\_\_\_

### 2 INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Date employed \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone# ( ) \_\_\_\_\_ - \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group# \_\_\_\_\_ ID# \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you met? \_\_\_\_\_  
Maximum annual benefit? \_\_\_\_\_

### 3 Do you have additional Insurance? NO \_\_\_\_\_ YES \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone# ( ) \_\_\_\_\_ - \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group# \_\_\_\_\_ Employer# \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you met? \_\_\_\_\_  
Maximum annual benefit? \_\_\_\_\_

### 4 PATIENT AGREEMENT

As a courtesy to our patients, Comprehensive Health and Chiropractic Centre is set up to utilize direct payment from insurance companies. However, it is important to understand that your health and accident insurance policy is an arrangement between you and your insurance company. You are personally responsible for all service charges incurred in our office. Until your insurance coverage has been verified, we expect payment in full when the services are rendered.

We ask that you keep our deductible charges current. After your deductible has been met, we request that you continue to keep your portion of your claim up to date. You are required to sign an "authorization and assignment of benefits" from and any other documents required by your insurance company on your first office visit. You are responsible for providing this office with insurance information and claim forms. You will be considered a cash-paying patient until this information is received. Our office does not guarantee that your insurance will pay. Regardless of what type of insurance you have, you are ultimately responsible for your account. Most insurance companies do not cover the cost of vitamin supplements and orthopedic supplies. Therefore, these costs are the responsibility of the patient. Payment must be made upon receipt of supplies.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date

### 5 AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and hereby release you of any consequence thereof.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collection counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at anytime, I agree to notify the office immediately.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Staff Signature Date

Greetings,

Dr. Kimberly Rollheiser is a detail-oriented doctor. It is in your best interest to fill out the forms as completely as possible. Doing so will help Dr. Rollheiser do a better job of diagnosing your health concerns and creating an effective healing plan designed especially for you.

The forms are broken down into the following sections:

**Section 1:** Current Health Concerns (what's bothering you that made you seek relief?)

**Section 2:** Musco-Skeletal (joint and muscle pain, tingling in the extremities, stiffness, etc.)

**Sections 3 – 10:** Problems with the Organ Systems of your body (appendectomy, tonsillectomy, heart attack, etc.)

<b>Section 3 – General</b>	<b>Section 4 – Nervous System</b>
<b>Section 5 – Genitro-Urinary</b>	<b>Section 6 – Cardiovascular/Respiratory</b>
<b>Section 7 – Eyes, Ears, Nose and Throat</b>	<b>Section 8 – Gastro-Intestinal</b>
<b>Section 9 – Female Problems</b>	<b>Section 10 – Male Problems</b>

**Sections 11 & 12 – Your Health and Your Family's Health Histories**

**Section 13 – Your Past Health History**

**Sections 14, 15, 16 & 17 – Your Diet/Exercise/Work Activity & Habits**

**Section 18 – Chiropractic Health Questionnaire**



## CURRENT HEALTH CONDITION

**Primary Unwanted Health Condition** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2nd Unwanted Health Condition** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3rd Unwanted Health Condition** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4th Unwanted Health Condition** \_\_\_\_\_

\_\_\_\_\_

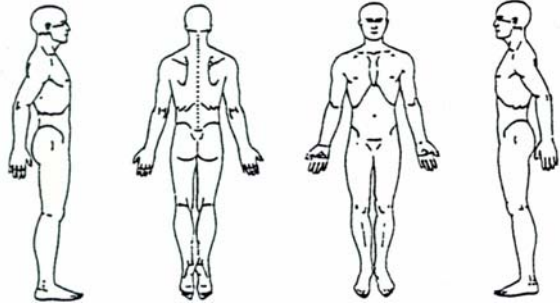
\_\_\_\_\_



MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#1 PAIN COMPLAINT: [ ]

- When did your symptoms appear?  
Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
- Is this condition getting progressively worse?  Yes  No  Unknown
- Describe your pain/complaint:  
 Dull  Sharp  Ache  Stabbing  
 Deep  Superficial  Spasm/tension  Numbness  
 Tingling  Burning  Stiffness  Pulling
- Radiation: Does the pain go to other parts of the body?  
 Yes  No Where? \_\_\_\_\_
- Degree: What is the degree of your pain?  
 Mild  Moderate  Severe
- Frequency: How often do you have this pain?  
 Occasional  Intermittent  Frequent  Constant
- Duration: How long does the pain last? \_\_\_Min. \_\_\_Hrs. \_\_\_Days
- What makes the pain worse?  
 Standing  Sitting  Bending  Twisting  
 Walking  Lifting  Sleeping  Heat  
 Cold  Stooping  Sex  Other \_\_\_\_\_
- What makes the pain better?  
 Sitting  Standing  Rest  Heat  Cold  
 Aspirin/medication  Other \_\_\_\_\_
- Does it interfere with your :  
 Work  Sleep  Daily routine  Recreation
- What treatment have you already received for this condition?  
 Medications  Surgery  Physical therapy  Chiropractic services  None  Other \_\_\_\_\_

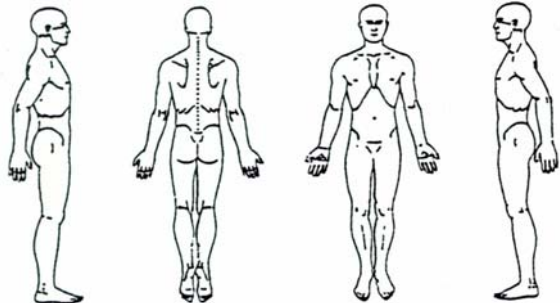


Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!  
Please circle the accurate pain level below (1-low; 10-high)  
1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT: [ ]

- When did your symptoms appear?  
Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
- Is this condition getting progressively worse?  Yes  No  Unknown
- Describe your pain/complaint:  
 Dull  Sharp  Ache  Stabbing  
 Deep  Superficial  Spasm/tension  Numbness  
 Tingling  Burning  Stiffness  Pulling
- Radiation: Does the pain go to other parts of the body?  
 Yes  No Where? \_\_\_\_\_
- Degree: What is the degree of your pain?  
 Mild  Moderate  Severe
- Frequency: How often do you have this pain?  
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- Duration: How long does the pain last? \_\_\_Min. \_\_\_Hrs. \_\_\_Days
- What makes the pain worse?  
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 Walking  Lifting  Sleeping  Heat  
 Cold  Stooping  Sex  Other \_\_\_\_\_
- What makes the pain better?  
 Sitting  Standing  Rest  Heat  Cold  
 Aspirin/medication  Other \_\_\_\_\_
- Does it interfere with your :  
 Work  Sleep  Daily routine  Recreation
- What treatment have you already received for this condition?  
 Medications  Surgery  Physical therapy  Chiropractic services  None  Other \_\_\_\_\_



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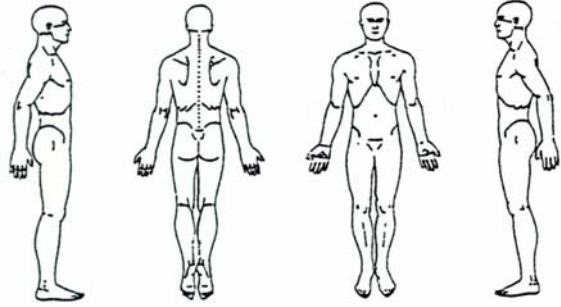
Please RATE YOUR PAIN!  
Please circle the accurate pain level below (1-low; 10-high)  
1 2 3 4 5 6 7 8 9 10



MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#3 PAIN COMPLAINT: [ ]

- 1. When did your symptoms appear? Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
2. Is this condition getting progressively worse?  Yes  No  Unknown
3. Describe your pain/complaint:
 Dull  Sharp  Ache  Stabbing
 Deep  Superficial  Spasm/tension  Numbness
 Tingling  Burning  Stiffness  Pulling
4. Radiation: Does the pain go to other parts of the body?
 Yes  No Where? \_\_\_\_\_
5. Degree: What is the degree of your pain?
 Mild  Moderate  Severe
6. Frequency: How often do you have this pain?
 Occasional  Intermittent  Frequent  Constant
7. Duration: How long does the pain last? \_\_\_ Min. \_\_\_ Hrs. \_\_\_ Days
8. What makes the pain worse?
 Standing  Sitting  Bending  Twisting
 Walking  Lifting  Sleeping  Heat
 Cold  Stooping  Sex  Other
9. What makes the pain better?
 Sitting  Standing  Rest  Heat  Cold
 Aspirin/medication  Other \_\_\_\_\_
10. Does it interfere with your :
 Work  Sleep  Daily routine  Recreation
11. What treatment have you already received for this condition?
 Medications  Surgery  Physical therapy  Chiropractic services  None  Other \_\_\_\_\_

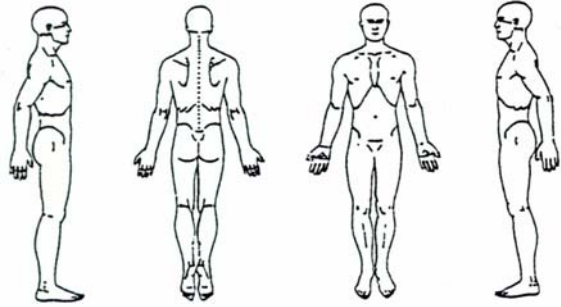


Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN! Please circle the accurate pain level below (1- low; 10-high) 1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT: [ ]

- 1. When did your symptoms appear? Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
2. Is this condition getting progressively worse?  Yes  No  Unknown
3. Describe your pain/complaint:
 Dull  Sharp  Ache  Stabbing
 Deep  Superficial  Spasm/tension  Numbness
 Tingling  Burning  Stiffness  Pulling
4. Radiation: Does the pain go to other parts of the body?
 Yes  No Where? \_\_\_\_\_
5. Degree: What is the degree of your pain?
 Mild  Moderate  Severe
6. Frequency: How often do you have this pain?
 Occasional  Intermittent  Frequent  Constant
7. Duration: How long does the pain last? \_\_\_ Min. \_\_\_ Hrs. \_\_\_ Days
8. What makes the pain worse?
 Standing  Sitting  Bending  Twisting
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9. What makes the pain better?
 Sitting  Standing  Rest  Heat  Cold
 Aspirin/medication  Other \_\_\_\_\_
10. Does it interfere with your :
 Work  Sleep  Daily routine  Recreation
11. What treatment have you already received for this condition?
 Medications  Surgery  Physical therapy  Chiropractic services  None  Other \_\_\_\_\_



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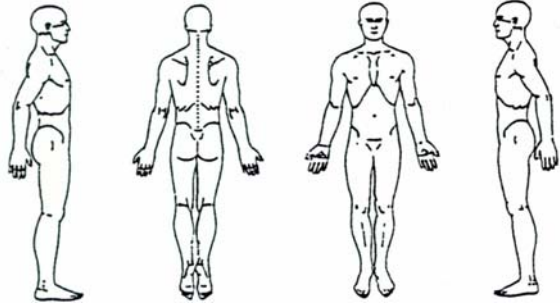
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MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#5 PAIN COMPLAINT: [ ]

- 1. When did your symptoms appear?  
Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
- 2. Is this condition getting progressively worse?  Yes  No  Unknown
- 3. Describe your pain/complaint:  
 Dull  Sharp  Ache  Stabbing  
 Deep  Superficial  Spasm/tension  Numbness  
 Tingling  Burning  Stiffness  Pulling
- 4. Radiation: Does the pain go to other parts of the body?  
 Yes  No Where? \_\_\_\_\_
- 5. Degree: What is the degree of your pain?  
 Mild  Moderate  Severe
- 6. Frequency: How often do you have this pain?  
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- 7. Duration: How long does the pain last? \_\_\_Min. \_\_\_Hrs. \_\_\_Days
- 8. What makes the pain worse?  
 Standing  Sitting  Bending  Twisting  
 Walking  Lifting  Sleeping  Heat  
 Cold  Stooping  Sex  Other \_\_\_\_\_
- 9. What makes the pain better?  
 Sitting  Standing  Rest  Heat  Cold  
 Aspirin/medication  Other \_\_\_\_\_
- 10. Does it interfere with your :  
 Work  Sleep  Daily routine  Recreation
- 11. What treatment have you already received for this condition?  
 Medications  Surgery  Physical therapy  Chiropractic services  None  Other \_\_\_\_\_

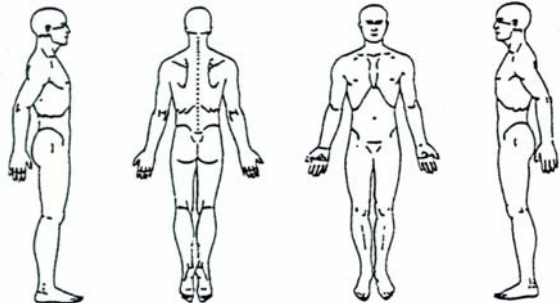


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Please RATE YOUR PAIN!  
Please circle the accurate pain level below (1- low; 10-high)  
1 2 3 4 5 6 7 8 9 10

#6 PAIN COMPLAINT: [ ]

- 1. When did your symptoms appear?  
Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
- 2. Is this condition getting progressively worse?  Yes  No  Unknown
- 3. Describe your pain/complaint:  
 Dull  Sharp  Ache  Stabbing  
 Deep  Superficial  Spasm/tension  Numbness  
 Tingling  Burning  Stiffness  Pulling
- 4. Radiation: Does the pain go to other parts of the body?  
 Yes  No Where? \_\_\_\_\_
- 5. Degree: What is the degree of your pain?  
 Mild  Moderate  Severe
- 6. Frequency: How often do you have this pain?  
 Occasional  Intermittent  Frequent  Constant
- 7. Duration: How long does the pain last? \_\_\_Min. \_\_\_Hrs. \_\_\_Days
- 8. What makes the pain worse?  
 Standing  Sitting  Bending  Twisting  
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- 9. What makes the pain better?  
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- 10. Does it interfere with your :  
 Work  Sleep  Daily routine  Recreation
- 11. What treatment have you already received for this condition?  
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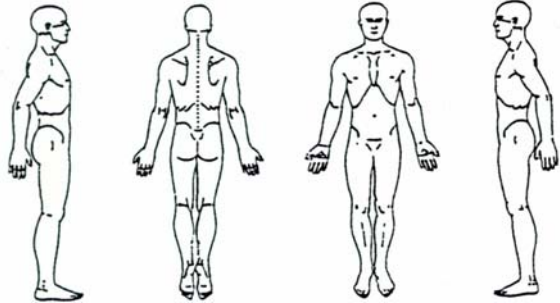
Please RATE YOUR PAIN!  
Please circle the accurate pain level below (1- low; 10-high)  
1 2 3 4 5 6 7 8 9 10



# MUSCULO-SKELETAL (neck, back, leg, etc.) *{fill out next four pages as needed}*

## #1 PAIN COMPLAINT:

- When did your symptoms appear?  
Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
- Is this condition getting progressively worse?  Yes  No  Unknown
- Describe your pain/complaint:  
 Dull  Sharp  Ache  Stabbing  
 Deep  Superficial  Spasm/tension  Numbness  
 Tingling  Burning  Stiffness  Pulling
- Radiation: Does the pain go to other parts of the body?  
 Yes  No Where? \_\_\_\_\_
- Degree: What is the degree of your pain?  
 Mild  Moderate  Severe
- Frequency: How often do you have this pain?  
 Occasional  Intermittent  Frequent  Constant
- Duration: How long does the pain last? \_\_\_Min. \_\_\_Hrs. \_\_\_Days
- What makes the pain worse?  
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- What makes the pain better?  
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 Aspirin/medication  Other \_\_\_\_\_
- Does it interfere with your :  
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- What treatment have you already received for this condition?  
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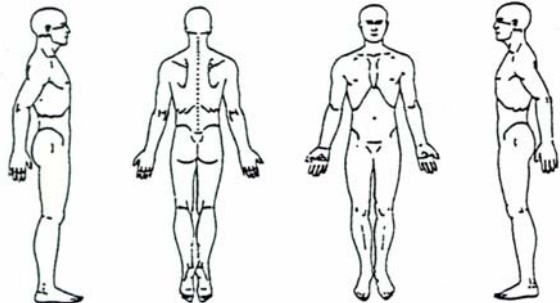


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Please **RATE YOUR PAIN!**  
Please circle the accurate pain level below (1- low; 10-high)  
**1 2 3 4 5 6 7 8 9 10**

## #8 PAIN COMPLAINT:

- When did your symptoms appear?  
Date of onset: \_\_\_\_\_ Was it:  Sudden  Gradual
- Is this condition getting progressively worse?  Yes  No  Unknown
- Describe your pain/complaint:  
 Dull  Sharp  Ache  Stabbing  
 Deep  Superficial  Spasm/tension  Numbness  
 Tingling  Burning  Stiffness  Pulling
- Radiation: Does the pain go to other parts of the body?  
 Yes  No Where? \_\_\_\_\_
- Degree: What is the degree of your pain?  
 Mild  Moderate  Severe
- Frequency: How often do you have this pain?  
 Occasional  Intermittent  Frequent  Constant
- Duration: How long does the pain last? \_\_\_Min. \_\_\_Hrs. \_\_\_Days
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- What makes the pain better?  
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 Aspirin/medication  Other \_\_\_\_\_
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**Draw/Shade** the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please **RATE YOUR PAIN!**  
Please circle the accurate pain level below (1- low; 10-high)  
**1 2 3 4 5 6 7 8 9 10**



## GENERAL

What is your primary concern with your **GENERAL HEALTH**? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fatigue:       Past    Present      If present:  Mild    Moderate    Severe      Daily?  Yes    No

Is there a pattern?  Yes    No   If Yes, describe: \_\_\_\_\_

Headaches:       Past    Present   If Present, how frequent?:    Daily    Weekly    Monthly

Degree:       Mild    Moderate    Severe   Location of pain: \_\_\_\_\_

Is there a pattern?  Yes    No   If Yes, describe: \_\_\_\_\_

How long has this pattern of headaches existed (days/weeks/months/years)? \_\_\_\_\_

Do you have any idea what causes or triggers your headaches? \_\_\_\_\_

Females only:      Is there a relationship to your menstrual cycle?  Yes    No

Allergies:       Airborne    Food    Unknown

List known allergies: \_\_\_\_\_

How often? Daily/weekly/monthly, or if seasonally, which seasons? \_\_\_\_\_

What kind of symptoms do you have with your allergies? \_\_\_\_\_

Bleeding Tendencies:      Where? \_\_\_\_\_      How often? \_\_\_\_\_

How severely? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Loss of Sleep:       Past    Present   If Present, how frequently does this occur? \_\_\_\_\_

When did this pattern begin? \_\_\_\_\_

Do you have difficulty falling asleep or staying awake? (circle one or both)       Yes    No

What factors do you think cause of influence this condition? \_\_\_\_\_

Skin Conditions:  Past    Present

Describe condition: \_\_\_\_\_

List past treatments and effectiveness: \_\_\_\_\_

Fever:

When was your last fever? \_\_\_\_\_

How often do you get fevers? \_\_\_\_\_

How severe do they get? \_\_\_\_\_



## NERVOUS SYSTEM

What is your primary concern with your *NERVOUS SYSTEM*? \_\_\_\_\_

\_\_\_\_\_

Nervousness

Do you consider yourself to be a "nervous type" in general? \_\_\_\_\_

Are you feeling nervous about something specific? \_\_\_\_\_

Forgetfulness

Are you forgetting recent events? \_\_\_\_\_

Events from the distant past? \_\_\_\_\_

Do you forget other things? \_\_\_\_\_

Is memory worse with stress? \_\_\_\_\_

Numbness

Where? \_\_\_\_\_

When did it start? \_\_\_\_\_

Frequency:  Occasional  Intermittent  Frequent  Constant

Dizziness:  Past  Present

Fainting:  Past  Present

Stress:  Past  Present

If present, what areas of your life do you consider to be stressful? \_\_\_\_\_

Depression:  Past  Present

If present, how long have you been depressed? \_\_\_\_\_

Have you ever taken prescribed medications for depression?  Yes  No

If yes, list medications: \_\_\_\_\_

Are you getting professional counseling?  Yes  No Is there a family history of depression?  Yes  No

Is your current depression related to a specific situation?  Yes  No

Is your depression:  Mild  Moderate  Severe

Cold or Tingling Extremities  Hands  Feet  Both Date of onset: \_\_\_\_\_

Frequency:  Occasionally  Intermittent  Frequent  Constant



## GENITRO URINARY

What is your primary concern with your *NERVOUS SYSTEM*? \_\_\_\_\_

\_\_\_\_\_

Bladder Infections:

When was your last one? \_\_\_\_\_ How often do you have one? \_\_\_\_\_

What factors do you think cause or influence this condition? \_\_\_\_\_

Frequent Urination: (other than associated with bladder infections) How frequent? (times per day) \_\_\_\_\_

Discolored Urine:  Past  Present If present, when did it begin? \_\_\_\_\_

Incontinence:  Past  Present If present, when did it begin? \_\_\_\_\_

Dribbling:  Past  Present If present, when did it begin? \_\_\_\_\_

Blood in Urine :  Past  Present If present, when did it begin? \_\_\_\_\_



## CARDIOVASCULAR/RESPIRATORY

What is your primary concern with your *CARDIOVASCULAR/RESPIRATORY SYSTEM*? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chest Pain:                       Past    Present   If present, when does it occur? \_\_\_\_\_  
Treatment? \_\_\_\_\_

Shortness of Breath:         Past    Present  
When does it occur? \_\_\_\_\_

Heart Disease:                 Past    Present  
Describe: \_\_\_\_\_

Ankle Swelling:               Past    Present  
If present, is it constant? \_\_\_\_\_

Blood Pressure Problems:    Past    Present                       High    Low  
Medication: \_\_\_\_\_

Lung Problems/Congestion:  
Describe: \_\_\_\_\_

Stroke:                      When? \_\_\_\_\_  
Residual problems? \_\_\_\_\_

Chronic Cough: \_\_\_\_\_ When did it start? \_\_\_\_\_                      Are you a smoker? \_\_\_\_\_

Irregular Heartbeat/Murmurs (circle one or both):  
Describe: \_\_\_\_\_  
Have you seen a medical doctor for this? \_\_\_\_\_

Varicose Veins:    Past    Present                      When did they start? \_\_\_\_\_                      Are they painful? \_\_\_\_\_  
What aggravates them? \_\_\_\_\_



## EYES, EARS, NOSE AND THROAT

What is your primary concern with your *EYE, EARS NOSE AND/OR THROAT*? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Vision Problems:       Past    Present   Specify problem: \_\_\_\_\_ When did it begin? \_\_\_\_\_

List treatments: \_\_\_\_\_

Earaches/Infections:       Past    Present      When was the last episode? \_\_\_\_\_

How often do they occur? \_\_\_\_\_      Severity of the problem? \_\_\_\_\_

List treatment: \_\_\_\_\_

Dental History:

List present problems: \_\_\_\_\_

List past problems: \_\_\_\_\_

Have you ever had braces/orthodontics?  Yes    No   Were teeth extracted as part of your treatment?  Yes    No

If yes, how many? \_\_\_\_\_      Who is your present dentist? \_\_\_\_\_

Hearing Difficulty:       Past    Present

Please describe: \_\_\_\_\_

When did it begin? \_\_\_\_\_      List any treatment and its effectiveness: \_\_\_\_\_

\_\_\_\_\_

Sore Throat:       Past    Present   If present, when did it begin? \_\_\_\_\_      How severe is it? \_\_\_\_\_

What do you think caused or influenced this condition? \_\_\_\_\_

List any treatment and its effectiveness: \_\_\_\_\_

Nose and Sinus Problems:  Past    Present

Describe: \_\_\_\_\_

When did it begin? \_\_\_\_\_      How severe is it? \_\_\_\_\_

What do you think causes or influences this condition? \_\_\_\_\_

List any treatment and its effectiveness: \_\_\_\_\_

Noises in Ear:       Past    Present

Describe: \_\_\_\_\_

When did it begin? \_\_\_\_\_

What do you think causes or influences this condition? \_\_\_\_\_



# GASTRO-INTESTINAL

What is your primary concern with your *GASTRO-INTESTINAL SYSTEM*? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Poor/Excessive Appetite (circle one or both):  Past  Present When did it start? \_\_\_\_\_

Weight change: As an adult, what has your weight range been? High: \_\_\_\_\_ Low: \_\_\_\_\_  
Do you feel you have an unhealthy relationship with food?  Yes  No Are you a compulsive eater?  Yes  No  
Are you or have you ever been considered:  Anorexic  Bulimic  
Do you feel over-concerned or obsessed with your weight and/or body image?  Yes  No

Heartburn: Frequency:  Occasional  Intermittent  Frequent  Constant  
All foods? \_\_\_\_\_ Certain foods only? \_\_\_\_\_  
Is there a time of day when it is worse? \_\_\_\_\_

Excessive Thirst:  Past  Present When did it begin? \_\_\_\_\_

Ulcers: When did it start? \_\_\_\_\_ Treatment? \_\_\_\_\_

Nausea:  Past  Present If present, frequency:  Occasional  Intermittent  Frequent  Constant

Vomiting:  Past  Present If present, when did it start? \_\_\_\_\_

Gas/Bloating After Meals:  Past  Present If present, all meals?  Yes  No  
Certain foods? \_\_\_\_\_

Abdominal Cramps/Pain:  Past  Present If present, location: \_\_\_\_\_  
When did they occur? \_\_\_\_\_ Intensity:  Mild  Moderate  Severe

Colitis:  Past  Present If present, when did it start? \_\_\_\_\_  
What factors effect it? \_\_\_\_\_

Bowel Movements: Times per day \_\_\_\_\_ Times per week \_\_\_\_\_

Diarrhea:  Past  Present If present, frequency:  Occasional  Intermittent  Frequent  Constant  
When did it start? \_\_\_\_\_

What do you think causes or influences it? \_\_\_\_\_

Is it related to:  Specific foods  Stress

Constipation:  Past  Present If present, when did it begin? \_\_\_\_\_

Is this a lifetime pattern?  Yes  No

What do you think causes or influences this condition? \_\_\_\_\_

Do you take any medications or natural substances to assist in bowel function (list) \_\_\_\_\_  
\_\_\_\_\_

Black/Bloody Stool:  Past  Present When did it start? \_\_\_\_\_

Hemorrhoids:  Past  Present Are they:  Painful  Bleeding  
What factors affect it? \_\_\_\_\_

Gall Bladder Problems:  Past  Present If present, describe symptoms: \_\_\_\_\_

Liver Problems:  Past  Present If present, describe symptoms: \_\_\_\_\_  
Time of day \_\_\_\_\_ Certain foods? \_\_\_\_\_ Other factors? \_\_\_\_\_

Hepatitis:  Past  Present When did it start? \_\_\_\_\_



# FEMALE PROBLEMS

What is your primary concern with your *FEMALE PROBLEMS*? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your age at first period: \_\_\_\_\_ Most recent period began date: \_\_\_\_\_

How many days do you flow? \_\_\_\_\_ How many days from period to period? \_\_\_\_\_

Last PAP smear: \_\_\_\_\_ History of abnormal PAP?  Yes  No

If Abnormal, what class? \_\_\_\_\_

Treatment? \_\_\_\_\_

Pregnancies: No, \_\_\_\_\_ Live births \_\_\_\_\_ Are you pregnant now?  Yes  No  Unsure

Nursing: \_\_\_\_\_ Breastfeeding:  Yes  No

Infertility: \_\_\_\_\_  Past  Present

Contraception: Past history of birth control pill use: \_\_\_\_\_ How long? \_\_\_\_\_ Side effects? \_\_\_\_\_

Past types:  IUD  Foam  Condoms  Other \_\_\_\_\_

Present types: \_\_\_\_\_

Menstrual Cramping: \_\_\_\_\_  Mild  Moderate  Severe

Do you get cramps every month?  Yes  No

If not, how often? \_\_\_\_\_

Spotting

PMS (Pre-menstrual Syndrome):  Yes  No If yes:  Mild  Moderate  Severe

How many days of symptoms before your period? \_\_\_\_\_

Check symptoms:

Breast tenderness:  Food cravings:  Irritability

Crying easily  Bloating/weight gain  Suicidal:

Other: \_\_\_\_\_

Painful Intercourse: \_\_\_\_\_  Past  Present

Breast Lumps/Fibrocystic: \_\_\_\_\_  Past  Present

Vaginal Infections/Yeast: \_\_\_\_\_  Past  Present Frequency, how many times per year? \_\_\_\_\_

DES Mother

Sexual Dysfunction: \_\_\_\_\_  Past  Present Describe: \_\_\_\_\_

Ovarian, Vaginal or Uterine Problems: \_\_\_\_\_  Past  Present

Treatment: \_\_\_\_\_



## MALE PROBLEMS

What is your primary concern with your *MALE PROBLEMS*? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prostate Problems:  Past  Present

If present, describe symptoms: \_\_\_\_\_ When did this begin? \_\_\_\_\_

List any treatment and its effectiveness: \_\_\_\_\_

Incomplete Voiding of Urine:  Past  Present

If present, describe symptoms: \_\_\_\_\_

When did this begin? \_\_\_\_\_

List any treatment and its effectiveness: \_\_\_\_\_

Pain during Urination:  Past  Present

If present, describe symptoms: \_\_\_\_\_ When did this begin? \_\_\_\_\_

List any treatment and its effectiveness: \_\_\_\_\_

Sexual Dysfunction:  Past  Present

If present, describe symptoms: \_\_\_\_\_ When did this begin? \_\_\_\_\_

List any treatment and its effectiveness: \_\_\_\_\_

**HEALTH HISTORY** – Please check the box(es) on the **LEFT SIDE** of the table that pertains to **YOU**; check the box(es) on the **RIGHT SIDE** of the page that pertains to your **FAMILY MEMBERS** (mother, father, sister, brother, cousin, aunt uncle, grandmother, etc.). If you have additional treatments, please write them on the back with the corresponding number (ex., put on back **8. Asthma – Proventil and Respiritone**).



YOUR HEALTH HISTORY				FAMILY HEALTH HISTORY			
	Ailments	Surgery Date	Age	Treatment	Relation	Deceased (Yes/No)	Age of Death
1	<input type="checkbox"/> AIDS/HIV					Yes / No	
2	<input type="checkbox"/> Alcoholism					Yes / No	
3	<input type="checkbox"/> Allergy Shots					Yes / No	
4	<input type="checkbox"/> Anemia					Yes / No	
5	<input type="checkbox"/> Anorexia					Yes / No	
6	<input type="checkbox"/> Appendicitis					Yes / No	
7	<input type="checkbox"/> Arthritis					Yes / No	
8	<input type="checkbox"/> Asthma					Yes / No	
9	<input type="checkbox"/> Bleeding Disorders					Yes / No	
10	<input type="checkbox"/> Breast Lump					Yes / No	
11	<input type="checkbox"/> Bronchitis					Yes / No	
12	<input type="checkbox"/> Bulimia					Yes / No	
13	<input type="checkbox"/> Cancer					Yes / No	
14	<input type="checkbox"/> Cataracts					Yes / No	
15	<input type="checkbox"/> Chemical Dependency					Yes / No	
16	<input type="checkbox"/> Chicken Pox					Yes / No	
17	<input type="checkbox"/> Cyst					Yes / No	
18	<input type="checkbox"/> Depression					Yes / No	
19	<input type="checkbox"/> Diabetes					Yes / No	
20	<input type="checkbox"/> Eczema					Yes / No	
21	<input type="checkbox"/> Emphysema					Yes / No	
22	<input type="checkbox"/> Epilepsy					Yes / No	
23	<input type="checkbox"/> Gallstones					Yes / No	
24	<input type="checkbox"/> Genital Warts					Yes / No	
25	<input type="checkbox"/> German Measles/Rubella					Yes / No	
26	<input type="checkbox"/> Glaucoma					Yes / No	
27	<input type="checkbox"/> Goiter					Yes / No	
28	<input type="checkbox"/> Gonorrhea					Yes / No	
29	<input type="checkbox"/> Gout					Yes / No	
30	<input type="checkbox"/> Heart Disease					Yes / No	
31	<input type="checkbox"/> Hemorrhoid					Yes / No	
32	<input type="checkbox"/> Hepatitis A					Yes / No	
33	<input type="checkbox"/> Hepatitis B					Yes / No	
34	<input type="checkbox"/> Hepatitis C					Yes / No	
35	<input type="checkbox"/> Hernia					Yes / No	
36	<input type="checkbox"/> Herniated Disc					Yes / No	
37	<input type="checkbox"/> Herpes					Yes / No	
38	<input type="checkbox"/> High Blood Pressure					Yes / No	
39	<input type="checkbox"/> High Cholesterol					Yes / No	
40	<input type="checkbox"/> Hysterectomy					Yes / No	
41	<input type="checkbox"/> Kidney Disease					Yes / No	
42	<input type="checkbox"/> Liver Disease					Yes / No	
43	<input type="checkbox"/> Lung Problems					Yes / No	
44	<input type="checkbox"/> Lupus					Yes / No	
45	<input type="checkbox"/> Measles					Yes / No	







## DIET – please describe your diet by indicating how many times per day/week/month you have the following:

Eggs	_____	times per	_____	Tea (caffeinated)	_____	times per	_____
Milk products	_____	times per	_____	Alcohol	_____	times per	_____
Wheat products:				Chocolate	_____	times per	_____
Pasta	_____	times per	_____	Other sweets	_____	times per	_____
Bread	_____	times per	_____	Soft drinks	_____	times per	_____
Rolls/muffins	_____	times per	_____	White flour products	_____	times per	_____
Red meat	_____	times per	_____	Water	_____	times per	_____
Chicken	_____	times per	_____	Fried food	_____	times per	_____
Fish	_____	times per	_____	Cigarettes	_____	times per	_____
Fresh vegetables	_____	times per	_____	Grains	_____	times per	_____
Fresh fruit	_____	times per	_____				
Salad	_____	times per	_____	Foods carved:			
Coffee	_____	times per	_____	Meals per day:			

## MISCELLANEOUS



EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Drug (Recreational)	Times/Week _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
	<input type="checkbox"/> Computer Work	<input type="checkbox"/> High Stress Level	Reason _____



## CHIROPRACTIC HEALTH QUESTIONNAIRE

Other prescription drugs: \_\_\_\_\_

Sleep \_\_\_\_\_ hrs/night      Do you sleep on your:     Back    Side    Stomach

Age of mattress \_\_\_\_\_ or waterbed \_\_\_\_\_      Is your bed comfortable?    No    Yes

What kind of pillow do you use?    Thick    Medium    Thin    None    Support      Age of pillow: \_\_\_\_\_

Do you wear:     Heel lifts    Shoe lifts    Arch supports    Orthotics, describe \_\_\_\_\_



## CHCC AGREEMENT

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.*

*I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.*

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.*

*I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.*

*Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature (if patient is minor)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date