

CONFIDENTIAL HEALTH HISTORY / BANACKI CHIROPRACTIC CLINIC

PERSONAL

NAME: _____ DATE: ____/____/____
HOME PHONE _____ WORK PHONE _____ NAME OF SPOUSE _____
ADDRESS: _____ CITY: _____ STATE/ZIP _____
AGE: _____ DATE OF BIRTH: ____/____/____ MARITAL STATUS: SINGLE _____ MARRIED _____ DIV _____
HOW MANY CHILDREN _____ OCCUPATION: _____
EMPLOYER _____ ADDRESS _____ CITY _____ ST/ZIP _____
EMERGENCY CONTACT _____ PHONE # _____
PRESENT FAMILY DOCTOR _____ ADDRESS _____ CITY _____ ST/ZIP _____
DATE OF LAST PHYSICAL _____ BY DOCTOR _____

LIST PRESENT COMPLAINTS:

1. _____ FOR HOW LONG? _____
2. _____ FOR HOW LONG? _____
3. _____ FOR HOW LONG? _____

LIST OTHER DOCTORS CONSULTED FOR THIS COMPLAINT

NAME: _____ ADDRESS: _____
DIAGNOSIS: _____ RESULT: _____
NAME: _____ ADDRESS: _____
DIAGNOSIS: _____ RESULT: _____

SURGERY (PLEASE INCLUDE ALL TYPES)

TYPE DATE DOCTOR

LIST MEDICATIONS AND / OR VITAMINS

TYPE FREQUENCY DOCTOR

PREVIOUS ACCIDENTS & INJURIES/FRACTURES

MEDICATIONS / GENERAL ALLERGIES

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST:

SCARLET FEVER RHEUMATIC FEVER PNEUMONIA POLIO TUBERCULOSIS ANEMIA
DIABETES HEART DISEASE PLEURISY CANCER ALCOHOLISM GOITER
ARTHRITIS MENTAL DISORDER EPILEPSY VENEREAL INFECTION

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST SIX (6) MONTHS:

GENERAL FEMALES ONLY CVR
ALLERGIES LAST PERIOD...WHEN CHEST PAIN
SLEEP LOSS ARE YOU PREGNANT? YES NO BLOOD PRESSURE PROBLEM
FEVER HEART PROBLEMS
LUNG PROBLEMS/CONGESTION

MUSCULO / SKELETAL
PAIN BETWEEN SHOULDERS
NECK PAIN
ARM PAIN
JOINT PAIN / STIFFNESS
WALKING PROBLEMS
DIFFICULT CHEWING / CLICKING JAW
LOW BACK PAIN

GASTRO INTESTINAL
POOR / EXCESSIVE APPETITE
EXCESSIVE THIRST
FREQUENT NAUSEA
VOMITING
DIARRHEA
CONSTIPATION
LIVER TROUBLE
GALL BLADDER PROBLEMS
BLACK / BLOODY STOOL
COLITIS

EENT
VISION PROBLEMS
HEARING DIFFICULTY
NERVOUS SYSTEM
NUMBNESS
PARALYSIS
DIZZINESS
FORGETFULNESS
CONFUSION / DEPRESSION
FAINTING
CONVULSIONS
COLD/TINGLING EXTREMITIES

MALE / FEMALE
URINARY INFECTION
BREAST PAIN / LUMPS
PROSTATE / SEXUAL DYSFUNCTION

HAVE YOU EVER HAD PREVIOUS CHIROPRACTIC CARE? _____ DATE OF LAST CARE _____

OUR OFFICE WILL TRY TO VERIFY YOUR INSURANCE AS A SERVICE TO YOU. YOU SHOULD ALSO VERIFY YOUR OWN INSURANCE. VERIFICATION OF INSURANCE IS NOT A GUARANTEE OF COVERAGE. ULTIMATELY YOU WILL BE RESPONSIBLE FOR YOUR HEALTH CARE.

PATIENT SIGNATURE _____ SOCIAL SECURITY NUMBER _____

Today's Date: _____ Patient: _____ File#: _____

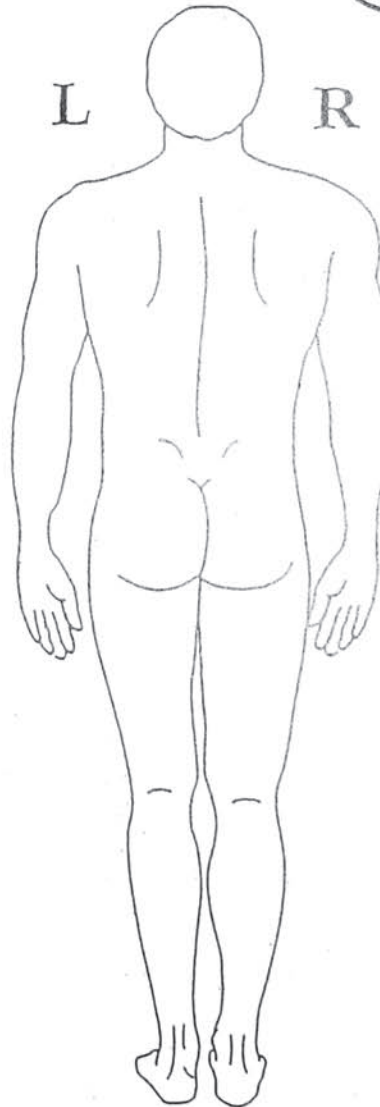
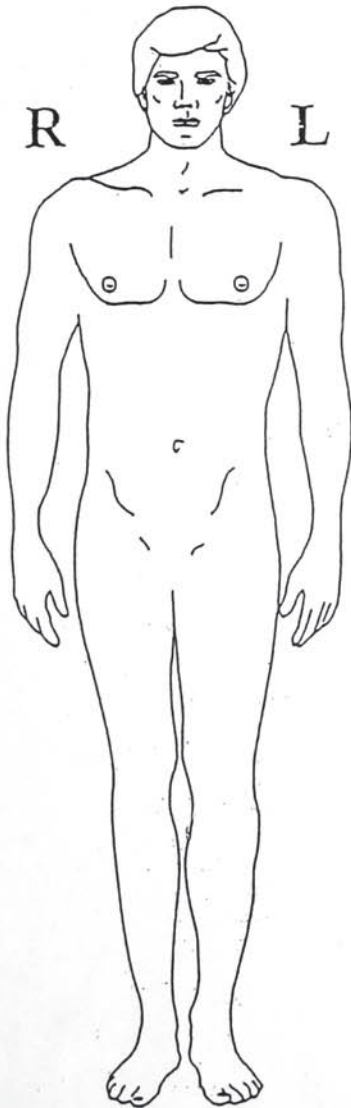
Current Complaints:

Use the symbols in the box to the right to mark the location and the type of pain or sensations you are feeling.

>>>	Aching Pain
XXX	Burning Pain
= = =	Numbness
oooo	Pins & Needles
////	Stabbing Pain

For Face or Head Pain:

Rt. Side Lt. Side Both



No Pain



Worst Possible Pain.

Please make a slash through this line as to the level of your pain.

Patient Signature