File # ______________

Date ______________

Patient Health History

Dr. Larry Formanek, D.C.

Knoxville Chiropractic Clinic, P.C.

In order to provide you the best chiropractic care, please complete the form as accurately as possible. All information is CONFIDENTIAL

PATIENT INFORMATION AND DEMOGRAPHICS

First Name ______________ M.I. ________ Last ______________ Nickname ________

Address ______________________ City ____________ State ______ Zip ______

Telephone (Home) ______________ (Cell) ______________ (Work) ______________

Email Address ______________________________________

Age ________ Birth Date ____________ ☐ Male ☐ Female

Occupation ______________________ Employer/ School ______________________

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name ______________ # of children ________

Emergency Contact ______________ Telephone # ______________ Relationship ________

How did you hear about us? ______________________________________

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name ______________ Date of last adjustment? ________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White (Caucasian) ☐ Other ☐ I decline to answer

Preferred Language: ☐ English ☐ Other ____________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I decline to answer

FINANCIAL INFORMATION

☐ I will be paying for the services myself (Cash Patient) ☐ Health Insurance* ☐ Auto Insurance ☐ Worker's Compensation

☐ Other If minor, who is responsible for the bill? ______________________

*** Please provide your insurance card to the front desk. A copy will be placed in your file**

PURPOSE OF THIS VISIT

What caused your symptoms? ______________________

Reason for this visit? ______________________

My symptoms started: ☐ gradually ☐ suddenly

When did your symptoms start? ______________________

My symptoms are getting: ☐ better ☐ worsening ☐ not changing

Intensity of your symptoms: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Frequency of pain: ☐ Constant (75-100% of the day) ☐ Frequent (50-75% of the day) ☐ Intermittent (25-50% of the day) ☐ Occasional (0-25% of the day)

Please select all that apply regarding your pain:

☐ Achy	☐ Numbness	☐ Shooting	☐ Stiffness
☐ Burning	☐ Radiating	☐ Soreness	☐ Tingling
☐ Dull	☐ Sharp	☐ Stabbing	☐ Other

The symptoms worsen when I..... ______________________

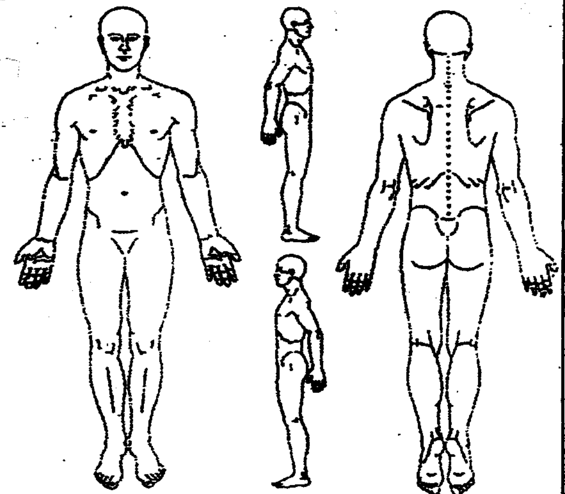
The symptoms improve when I.... ______________________

Home remedies used: ☐ Ice ☐ Heat ☐ Tylenol ☐ Ibuprofen ☐ Other

Who have you seen for your symptoms? ☐ No One ☐ Chiropractor ☐ MD ☐ Surgeon ☐ Physical Therapist ☐ Other

What treatments were performed? ☐ X-ray ☐ MRI ☐ Therapy ☐ Other

Please indicate where you have pain or other symptoms:



Comments ______________________
____
____

For office use only: Height ________inches Weight __________ lbs. BP ___________ Pulse ________ Temp.______

Health and Social History

Have you ever had any surgeries? ☐ Yes ☐ No Please State: ______________________________

Have you ever had any car accidents? ☐ Yes ☐ No Please State: ______________________________

Sports Injuries, falls, broken bones? ☐ Yes ☐ No Please State: ______________________________

Smoking Status: ☐ Every day smoker/ # of packs per day: _____ ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Do you consume alcohol? ☐ Yes ☐ No # of drinks per week: _______

Do you exercise? ☐ No ☐ Infrequently ☐ Occasionally ☐ Frequently ☐ Regularly

Are you pregnant? ☐ Yes ☐ No Number of weeks: _______ Anticipated due date: ________

Are you currently taking any medications? ☐ Yes ☐ No (Please include prescriptions and regularly used over the counter medications.)

____

____

____

Do you have any medication allergies? ☐ Yes ☐ No Please State: ______________________________

Personal History & Review of Systems **Please check all that you have or have had:**

☐ AIDS	☐ Fever	☐ Nosebleeds	☐ Pacemaker	☐ Hot flashes
☐ Alcoholism	☐ Loss of Sleep	☐ Sinus infection	☐ Poor circulation	☐ Menstrual pain
☐ Allergies	☐ Uncontrolled sweating	**Muscle/Joint/Bone**	☐ Rapid heartbeat	☐ painful intercourse
☐ Anemia	☐ Weight gain	☐ Arthritis	☐ Swelling of ankles	☐ vaginal discharge
☐ Anxiety/Nervousness	☐ Weight loss	☐ Disc degeneration	☐ Varicose Veins	
☐ Appendicitis	**Gastro-intestinal**	☐ Back pain/stiffness	**Skin**	
☐ Asthma	☐ Bloating	☐ Neck pain/stiffness	☐ Changes in moles	
☐ Cancer	☐ Constipation	☐ Muscle pain	☐ Bruises easily	
☐ Chills	☐ Diarrhea	☐ Muscle spasm	☐ Hives	
☐ Cold extremities	☐ Excessive thirst	☐ Osteoporosis	☐ Itching	
☐ Decreased activity	☐ Hemorrhoids	☐ Joint pain	☐ Rashes	
☐ Depression	☐ Indigestion	☐ Swollen joints	☐ Scars	
☐ Diabetes	☐ Nausea	☐ Scoliosis	☐ Sores that won't heal	
☐ Dizziness	☐ Change in appetite	**Urinary**	**Males only**	
☐ Epilepsy	☐ Stomach pain	☐ Blood in urine	☐ Breast lump	
☐ Eye Pain	☐ Vomiting	☐ Frequent urination	☐ Erectile dysfunction	
☐ Fatigue	**Ear/Nose/Throat**	☐ loss of bladder control	☐ Lump in testicle	
☐ Kidney Infection	☐ Blurred vision	☐ nocturia (bedwetting)	☐ Prostrate problems	
☐ Kidney Stones	☐ Double vision	☐ painful urination	☐ Penis discharge	
☐ Loss of memory	☐ Earache	☐ trouble starting/stopping stream	☐ Sore penis	
☐ Migraine Headache	☐ Loss of hearing	**Cardiovascular**	**Females only**	
☐ Sciatica	☐ Ringing in ears	☐ Chest pain	☐ Breast lump	
☐ Shortness of Breath	☐ Hoarseness	☐ High blood pressure	☐ Nipple pain/discharge	
☐ Stroke	☐ Difficulty swallowing	☐ Low blood pressure	☐ Abnormal pap smear	
☐ Thyroid Condition	☐ Persistent Cough	☐ Irregular heartbeat	☐ Irregular cycle	

Family History **Please note any family history of the following conditions and include relationship of relative to you:**

☐ Cancer ____________	☐ Arthritis ____________	☐ Spine or back disorder ____________
☐ Diabetes ____________	☐ Epilepsy ____________	☐ Multiple Sclerosis ____________
☐ Headache ____________	☐ Heart Disease ____________	☐ Psychological Problems ____________
☐ High Blood Pressure ____________	☐ Stroke ____________	☐ Other ____________

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank because of the nature and frequency of chiropractic care.)

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

______________________________ ______________

Patient or Guardian of Minor Patient s Signature Date