File # _____ Dr. Larry Formanek, D.C.

Date _____ **Patient Health History** 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? _____

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:

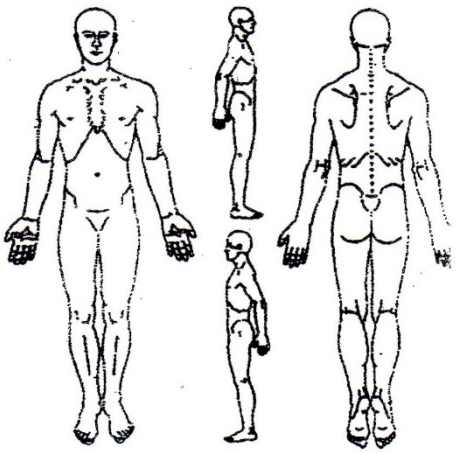
☐ Achy	☐ Numbness	☐ Shooting	☐ Stiffness
☐ Burning	☐ Radiating	☐ Soreness	☐ Tingling
☐ Dull	☐ Sharp	☐ Stabbing	☐ Other

The symptoms worsen when I_____

The symptoms improve when I_____

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

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 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 relationships 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