Welcome to.....SISK CHIROPRACTIC

Confidential Patient Health Record Date_____

PERSONAL HISTORY

Name_____Birth Date_____Age_____Sex M__F__

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____

Email Address_____

Social Secruity# _____Circle One: Married –Single- Widowed- Divorced- Separated

Employer_____Type of Work_____ Phone_____

Name of Spouse_____Spouse's Employer_____Phone_____

Name of Emergency Contact_____Number_____Relationship_____

Referred to this Office By_____

Primary insurance holders
Name_____Date of Birth_____Relationship_____

CURRENT HEALTH CONDITION

Purpose of this appointment_____

Have you seen other Dr's for this condition_____Results_____

Previous chiropractic Care?_____Dr's Name_____-_____

When did this condition begin?_____Has it Occurred before_____

Is condition: Job related_____Auto_____Home Injury_____Fall_____Other_____Date_____

Have you made a report of your accident to your employer: Yes_____No_____

Any other medical conditions?_____

List of Medications:_____

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness:	☐ ADD	☐ Allergies/Hayfever	☐ Asthma	☐ Atopic Dermatitis	☐ Cerebral Palsy	☐ Chicken Pox
☐ None	☐ Depression	☐ Diabetes	☐ Fetal Drug Exposure	☐ Food Allergies	☐ Headaches	☐ Hepatitis
	☐ Measles	☐ Mumps	☐ Rash	☐ Seizure Disorder	☐ Sickle Cell Anemia	☐ Spina Bifida
	☐ Unusual Childhood Illnesses					

Adult Illnesses:	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Cancer	☐ Chicken Pox	☐ CRPS (RSD)
☐ None	☐ CVA (Stroke)	☐ Depression	☐ Diabetes (Insulin Dep)	☐ Diabetes (NIDDM - Noninsulin)	☐ Eye Problems	☐ Heart Disease
	☐ Hepatitis	☐ Hypertension	☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Psychiatric Problems
	☐ Seizures	☐ Similar Symptoms	☐ STD's	☐ Suicide Attempts	☐ Thyroid Problems	

Surgeries:	☐ Angioplasty	☐ Appendectomy	☐ Caesarian Section	☐ Cardiac Catheterization	☐ Carpal Tunnel Repair	☐ Coronary Bypass
☐ None	☐ Cosmetic	☐ D&C	☐ Hemorrhoidectomy	☐ Hernia Repair	☐ Hysterectomy	☐ Joint Reconstruction
	☐ Joint Replacement	☐ Laminectomy	☐ Mastectomy	☐ Pacemaker Insertion	☐ Spinal Fusion	☐ Tonsillectomy

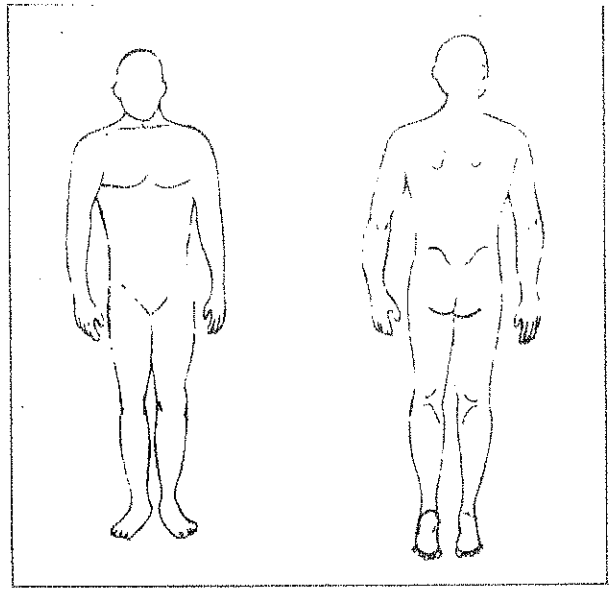
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

Numbness: — — — — — —

Burning: x x x x x x

Pins & needles: o o o o o o

Stabbing: / / / / / /



DAILY PATIENT PROGRESS REPORT

Please describe your current complaint _____

On a scale of zero to ten, I rate my discomfort as follows: (Place an X)

(_____)

▲ 0 (No Pain) (Severe Pain) ▲ 10

Check any of the following diseases you have had:

_Pneumonia
_Rheumatic Fever
_Polio
_Tuberculosis
_Whooping Cough
_Anemia
_Measles
_Mumps
_Small Pox
_Chicken Pox
_Diabetes
_Cancer
_Heart Disease
_Thyroid
_Influenza
_Pleurisy
_Arthritis
_Epilepsy
_Mental Disorders
_Lumbago
_Eczema

INTAKE

_Coffee
_Tea
_Alcohol
_Cigarettes
_White Sugars

Check any of the following you have had in the past 6 months;
Musculo-Skeletal Code;

_Low back pain
_Pain between shoulders
_Neck Pain
_Arm Pain
_Joint Pain/Stiffness
_Walking Problems
_Difficult Chewing/Clicking Jaw
_ General Stiffness

_Gas/Bloating after meals
_Heartburn
_Black/Bloody Stool
_Colitis

_Fatigue
_Allergies
_Loss of Sleep
_Fever
_Headache

GENITO-URINARY CODE

_Bladder Trouble
_Painful/Excessive Urination
_Discolored Urine

NERVOUS SYSTEM

_Nervous
_Numbness
_Paralysis
_Dizziness
_Forgetfulness
_Confusion/Depression
_Cold/Tingling Extremities
_Stress
_Convulsions

C-V-R CODE

_Chest Pain
_Short Breath
_Blood Pressure Problems
_Irregular Heartbeat
_Heart Problems
_Lung Problems/Congestion
_Varicose Veins
_Ankle Swelling
_Stroke

GASTRO-INTESTINAL CODE

_Poor/Excessive Appetite
_Excessive Thirst
_Frequent Nausea
_Vomiting
_Diarrhea
_Constipation
_Hemorrhoids
_Liver Problems
_Gall Bladder Problems
_Weight Trouble
_Abdominal Cramps

MALE FEMALE CODE

_Menstrual Irregularity
_Menstrual Cramps
_Vaginal Pain/Infection
_Breast Pain/Lumps
_Prostate/Sexual Dysfunction
_Other Problems

_____
_____

HISTORY

Does any other family member have similar medical problems as you?_____
_____

OUTLINE OF PROCEDURE FOR NEW PATIENTS

STEP ONE:

All new patients are requested to fill out a personal health/history questionnaire.

STEP TWO:

Your first consultation with the doctor to discuss your health problems.

STEP THREE:

Chiropractic examination and Orthopedic and Neurological examinations are related to chiropractic to determine chiropractic care for you.

STEP FOUR:

The doctor will advise you as to the need of additional procedures such as X-ray test, if necessary.

STEP FIVE:

You will be given a "Report of Findings" on your next visit. The doctor will inform you as to the cause of your problem. You will also be advised concerning how our office procedures work.

STEP SIX:

After you receive your report of findings and understand how Chiropractic works, you will be given a choice as to how you would like us to help you.

STEP SEVEN:

Adjustments will begin and continue as scheduled until maximum correction for you has been obtained.

STEP EIGHT:

After maximum correction, a schedule of care will be recommended to help prevent future problems and maintain good health.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature X _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____