

**Bellevue Chiropractic Neurology, Inc.
Confidential Patient Information**

Date _____

Name _____			Age _____		Date of Birth _____	
Male/ Female		Married/Single		Number of Children _____		
Address _____						
City/State/Zip _____						
Driver's License # _____						
Telephone (h) _____		(w) _____		(cell) _____		
E-mail _____						
Emergency Contact _____						

Who referred you to us? _____						

Work Status: FT PT FT Student PT Student Disabled

Occupation: _____

Reason for visit: _____

Please list all doctors/therapists you have seen related to your current concern. If possible, please list the approximate date of the last visit and the practitioner's city and telephone number.

1.	4.
2.	5.
3.	6.

Health Concerns

Please list your major ailments in order of severity (from most debilitating to least debilitating)

1.	4.
2.	5.
3.	6.

1. What is your major concern? _____

2. When did you first notice symptoms? _____

3. Onset: Immediate or Gradual. Briefly describe: _____

4. How often do you experience these symptoms?

Constant (100% of day) _____	Seldom (25% of day) _____
Frequent (75% of day) _____	Rarely (less than 25%) _____
Often (50% of day) _____	Other: _____

5. Please mark an "X" on the line to indicate the severity of your condition:

No symptoms No problems with daily activities	-----	Extreme symptoms Disabling
☺		☹

6. Have your symptoms changed recently? Better _____ Worse _____ Same _____

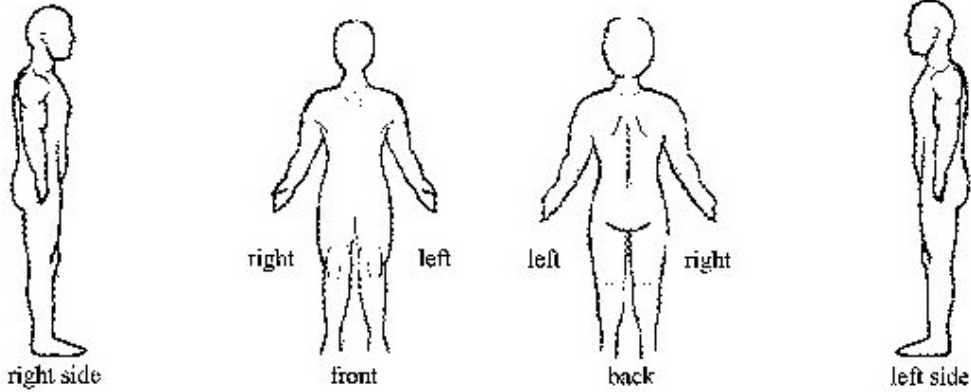
7. What makes it better? _____ Worse _____

8. Is this affecting your sleep? Yes _____ No _____ If yes, please describe: _____

9. Is this affecting your ability to perform your job or daily activities? Yes _____ No _____

If yes, please describe: _____

Please mark any areas of concern on the diagrams below.
 P- pins & needles N- numbness B- burning A- aching S- stabbing



Personal Health History

Please list your current medications, how long you have been taking them and for what reason.

Medications	Dosage	How long?	What reason?

Please list your current vitamins/ supplements, how long you have been taking them and for what reason.

Supplement	Dosage	How long?	What reason?

Please list any allergies you have.

Personal Health History cont'd.

Have any of your **family members** ever suffered from any of the following?

Diabetes _____	Heart Disease _____	Stroke _____	Depression _____
Neurological Disorders _____		Autoimmune Disorders _____	
Cancer _____			
Other _____			

General Health History: Have **you** had any of the following?

Injuries, Accidents, Falls, Traumas:	No	Yes (explain)
Illnesses/Hospitalizations	No	Yes (explain)
Surgeries	No	Yes (explain)
Motor Vehicle Accidents	No	Yes (explain)
Work Injuries	No	Yes (explain)

Health Habits

Smoking	No	Yes-	How much per week? Years?	_____
Alcohol	No	Yes-	How many drinks per week?	_____
			What do you drink?	_____
Substance Abuse	No	Yes-	Which substances? How often?	_____
Water	No	Yes-	How much water per day?	_____
Coffee	No	Yes-	How many cups per day?	_____
Tea	No	Yes-	How many cups per day?	_____
Soft Drinks	No	Yes-	How many cans per day?	_____
			Diet / Regular	_____
Sleep			How many hours per night?	_____
Exercise			How many times per week?	_____
Eating			How many meals per day	_____
Fast Food			How many fast food meals per week?	_____

Please mark an "X" on the line that best describes:

Your **eating habits** (types of food, attention, speed of eating, number of meals per day, sugar intake, junk food) are:

Excellent Extremely Poor
☺ ----- ☹

Your **exercise habits** (frequency, enjoyment, perceived benefits)

Excellent Extremely Poor
☺ ----- ☹

Your **overall lifestyle** (stress level, fun, attention to good health)

Excellent Extremely Poor
☺ ----- ☹

Your **overall health** (physical & emotional health)

Excellent Extremely Poor
☺ ----- ☹

Survey of Your Health History

Please circle all that apply. Indicate whether this is a new or old concern by providing an approximate date.

1. General

Fever
Night Sweats
Nervousness
Bleeding
Diabetes
Thyroid problems
Headache
Chills
Fatigue
Weight Loss/Gain
Anemia
Cancer
Substance Abuse
Phobias
Problems Falling Asleep

2. Nervous System

Depression
Memory Loss
Confusion
Seizures
Dizziness
Loss of Consciousness
Poor Balance
Twitches/Tremor
Tingling
Numbness
Headaches
Other _____

3. Gastrointestinal

Belching/gas
Vomiting
Bloody Stools
Hernia
Constipation
Diarrhea
Irregular bowel movements
Abdominal Pain
Nausea
Liver Problems
Other _____

4. Respiratory

Breathing problems
Coughing Blood
Allergies
Asthma
Shortness of Breath
Wheezing
Pneumonia
Tuberculosis
Other _____

5. Cardiovascular

High Blood Pressure
Stroke
Swelling in ankles
Irregular heartbeat
Racing Heart
Chest Pain
Valve Disease
Pacemaker
Other _____

6. Musculoskeletal

Pain
Stiffness
Swelling
Arthritis
Spinal Curve
Weakness
Other _____

7. Skin

Rashes
Mole Changes
Itching
Nail Changes
Redness
Other _____

8. EENT

Blurry Vision
Double Vision
Eye Pain
Jaw Pain
Hearing Loss
Ringing in Ears
Ear Infection
Sinus Problems
Nosebleeds
Throat Problems
Speech Problems
Glasses/Contacts _____
Other _____

9. Genitourinary

Frequent/Painful Urination
Incontinence
Blood in Urine
Urinary tract infection
Discolored urine
Sexual Dysfunction
Other _____

10. Women only

Hot flashes
Difficult periods
Irregular cycles
Breast Pain
Lump in breast
Difficulty becoming pregnant
Other _____

11. Men only

Testicular pain
Prostate problems
Difficulty with erection
Other _____

CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number?	Yes	No
May we leave a message for you on your home answering machine?	Yes	No
May we leave a message for you with someone at your work phone number?	Yes	No
May we fax information that you request?	Yes	No

Agreement for Payment of Services (please initial each statement)

_____ I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Bellevue Chiropractic Neurology does not participate in any HMO/PPO organizations.

_____ I understand that the office of Bellevue Chiropractic Neurology will not file insurance claims for me. I understand that I may be provided with diagnosis codes and receipts so that I may file my own claim. The office of Bellevue Chiropractic Neurology makes no guarantee of reimbursement from your insurance provider.

_____ I understand that I am personally responsible for payment at the time of services.

Signature

Date