



Welcome

PATIENT INFORMATION

NAME		DATE	SOCIAL SECURITY#	
STREET ADDRESS			P.O. BOX (street address also needed)	
CITY			STATE	ZIP
DO YOU PREFER PHONE CALLS AT: <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> NO PREFERENCE			BEST TIME TO CALL	
HOME PHONE		CELL PHONE	WORK PHONE	
DO YOU HAVE E-MAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO		EMAIL ADDRESS (Necessary for important notices and newsletters)		
AGE	BIRTHDATE	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER		
PATIENT EMPLOYER/SCHOOL			OCCUPATION	
EMPLOYER ADDRESS				
CITY			STATE	ZIP
SPOUSE OR PARENT NAME			CONTACT PHONE	
HOW DID YOU HEAR OF MELBY CHIROPRACTIC? <input type="checkbox"/> WEBSITE <input type="checkbox"/> MAILER <input type="checkbox"/> WORD OF MOUTH <input type="checkbox"/> SIGN <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> OTHER				
WHOM MAY WE THANK FOR REFERRING YOU TO US?				

RESPONSIBLE PARTY (If other than patient)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT		RELATIONSHIP TO PATIENT		
PHONE		ADDRESS		
CITY			STATE	ZIP
NAME OF EMPLOYER			WORK PHONE	

INSURANCE INFORMATION

NAME OF POLICY HOLDER		RELATIONSHIP TO PATIENT		
POLICY HOLDER'S BIRTHDATE		POLICY HOLDER'S SOCIAL SECURITY NUMBER		
NAME OF EMPLOYER (if not stated above)			WORK PHONE	
EMPLOYER ADDRESS				
CITY			STATE	ZIP

HEALTH INFORMATION

REASON FOR VISIT <input type="checkbox"/> WELLNESS CARE <input type="checkbox"/> OTHER (please explain):				
DATE OF YOUR LAST PHYSICAL EXAM				
WOMEN: ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MAYBE NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO				
LIST ANY ALLERGIES YOU ARE AWARE OF:				
<input type="checkbox"/> Animals <input type="checkbox"/> Aspirin <input type="checkbox"/> Bees <input type="checkbox"/> Chocolate <input type="checkbox"/> Dairy <input type="checkbox"/> Dust <input type="checkbox"/> Eggs <input type="checkbox"/> Latex <input type="checkbox"/> Molds <input type="checkbox"/> Penicillin <input type="checkbox"/> Ragweed/Pollen <input type="checkbox"/> Rubber <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Shellfish <input type="checkbox"/> Soaps <input type="checkbox"/> Wheat <input type="checkbox"/> X-ray Dye <input type="checkbox"/> Other				
CONTINUE ON BACK →				

LIST ANY SURGERIES YOU HAVE HAD AND DATES:

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other:

LIST ANY MEDICATIONS YOU MAY CURRENTLY BE TAKING:

Anxiety Muscle Relaxors Pain Killers Insulin Birth Control Cardiovascular Allergy Seizure Other:

HEALTH HISTORY

CHECK ALL THOSE WHICH ARE APPLICABLE:

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Migraine | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatoid Arthritis. |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Fractures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |

CHECK ALL THAT APPLY TO YOUR FAMILY HISTORY:

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition High Blood pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio Prostate Problems Shoulder Pain Stroke/Heart Attack Other:

DATE OF YOUR LAST PHYSICAL EXAMINATION

HAVE YOU HAD ANY OTHER ACCIDENTS? YES NO

DAILY HABITS

WHAT TYPE OF EXERCISE DO YOU PARTICIPATE IN? (ex: walking, running, aerobics, weight training, etc.)

HOW OFTEN DO YOU EXERCISE? LESS THAN WEEKLY _____ TIMES PER WEEK

WHAT DO YOUR DAILY WORK HABITS INCLUDE? (ex: sitting, standing, light labor, heavy labor, computer work):

DO YOU SMOKE? YES NO PIPE CIGAR CIGARETTES OTHER?

HOW MUCH PER DAY?

HOW MUCH ALCOHOL DO YOU CONSUME ON A WEEKLY BASIS?

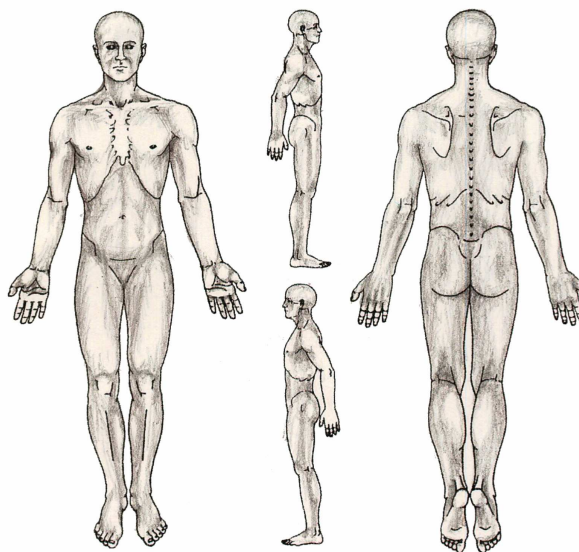
HOW MUCH COFFEE OR CAFFEINATED BEVERAGES DO YOU CONSUME ON A DAILY BASIS?

COMPLAINTS / SYMPTOMS

PLEASE USE THE LETTERS IN THE KEY TO INDICATE THE TYPE AND LOCATION OF THE SENSATIONS YOU ARE EXPERIENCING:

KEY:

- A= ACHE
- B= BURNING
- N= NUMBNESS
- P= PINS & NEEDLES
- S= STABBING



MAIN REASON FOR CONSULTING THE OFFICE:

- BECOME PAIN FREE
- EXPLANATION OF MY CONDITION
- LEARN HOW TO CARE FOR MY CONDITION
- REDUCE SYMPTOMS
- RESUME NORMAL ACTIVITY LEVEL

WHAT IS YOUR MAJOR COMPLAINT:

DATE PROBLEM BEGAN:

HOW DID THIS PROBLEM BEGIN (FALLING, LIFTING, ETC.):

HAVE YOU HAD THIS CONDITION BEFORE: YES NO

HOW IS YOUR CONDITION CHANGING: BETTER WORSE SAME

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM:

CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day) OCCASIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

SHARP DULL NUMB BURNING SHOOTING TINGLING RADIATING PAIN TIGHTNESS

STABBING THROBBING OTHER:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

(0= no pain and 10= excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING:

(0= no affect and 10= fully unable to perform activities): 0 1 2 3 4 5 6 7 8 9 10

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION (working, exercise, etc.):

WHAT MAKES YOUR SYMPTOMS BETTER (ice, heat, massage, etc.):

WHAT IS YOUR SECOND COMPLAINT:

DATE PROBLEM BEGAN:

HOW DID THIS PROBLEM BEGIN (FALLING, LIFTING, ETC.):

HAVE YOU HAD THIS CONDITION BEFORE: YES NO

HOW IS YOUR CONDITION CHANGING: BETTER WORSE SAME

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM:

CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day) OCCASIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

- SHARP DULL NUMB BURNING SHOOTING TINGLING RADIATING PAIN TIGHTNESS
 STABBING THROBBING OTHER:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

(0= no pain and 10= excruciating pain): 1 2 3 4 5 6 7 8 9 10

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING:

(0= no affect and 10= no possible activities): 1 2 3 4 5 6 7 8 9 10

WHAT ACTIVITIES AGRAVATE YOUR CONDITION (working, exercise, etc.):

WHAT MAKES YOUR SYMPTOMS BETTER (ice, heat, massage, etc.):

WHAT IS YOUR NEXT COMPLAINT:

DATE PROBLEM BEGAN:

HOW DID THIS PROBLEM BEGIN (FALLING, LIFTING, ETC.):

HAVE YOU HAD THIS CONDITION BEFORE: YES NO

HOW IS YOUR CONDITION CHANGING: BETTER WORSE SAME

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM:

CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day) OCCASIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

- SHARP DULL NUMB BURNING SHOOTING TINGLING RADIATING PAIN TIGHTNESS
 STABBING THROBBING OTHER:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

(0= no pain and 10= excruciating pain): 1 2 3 4 5 6 7 8 9 10

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING:

(0= no affect and 10= no possible activities): 1 2 3 4 5 6 7 8 9 10

WHAT ACTIVITIES AGRAVATE YOUR CONDITION (working, exercise, etc.):

WHAT MAKES YOUR SYMPTOMS BETTER (ice, heat, massage, etc.):

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, or my minor child have insurance coverage with _____(name of ins. co.) and assign directly to Melby Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Melby Chiropractic Clinic may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

DATE

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

DATE