Prairie Winds Chiropractic
Linda M. Johnston, D. C.
115 6th St.
Clay Center, KS 67432

# CONFIDENTIAL HEALTH INFORMATION

Date _____ Have you consulted a chiropractor before? Yes or No

Whom may we thank for referring you? _____

Age_____ Birth Date: _____ Gender: _____Male _____Female

| Race | Ethnicity | Marital Status | Smoking Status |
|---|---|---|---|
| _____White | ____ Hispanic or Latino | _____ Married | _____ Never a smoker |
| _____American Indian | ____Not Hispanic or Latino | _____ Single | _____ Former smoker |
| _____Asian | ____Decline to specify | _____ Divorced | _____ Current every day |
| _____Black or Black American | | _____ Other | _____ Current some days |
| _____Other | | | |
| _____Decline to answer | Preferred Language _____ (English) | | |

Last Name _____ Social Security # _____

First Name_____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Preferred method of phone contact? Home _____ Cell _____

Email Address _____ Spouse's Name _____

Emergency Contact _____ Emergency Contact Phone _____

Your Employer _____ Your Occupation _____

Address_____ City_____ State _____

May we contact you at work? Yes_____ No _____ Phone Number _____

Primary Care Physicians Name _____

**Primary symptom: What hurts and what did you do to make it hurt?**

_____

_____

_____

_____

**Is this the result of accident or injury?**

Yes _____ No_____

**Work related (Workman's Comp)?**

Yes _____ No_____

**Onset: When did symptoms start?**

_____

**Secondary Symptom (if needed)**

_____

_____

_____

_____

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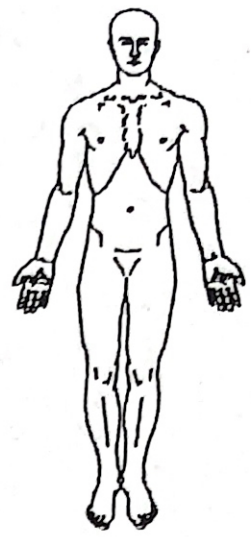
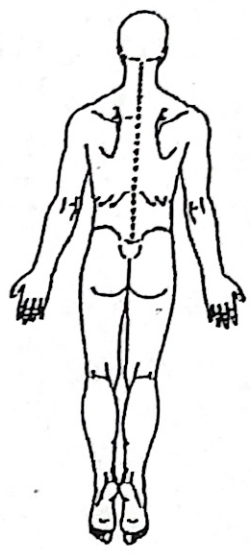
_____

Patient Name

**Location**
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past





## 1. Illnesses (check all that apply)

- o Aids
- o Alcoholism
- o Allergies
- o Arteriosclerosis
- o Cancer
- o Chicken pox
- o Diabetes
- o Epilepsy
- o Glaucoma
- o Goiter
- o Gout
- o Heart disease
- o Hepatitis
- o HIV Positive
- o Malaria
- o Measles
- o Multple Sclerosis
- o Mumps
- o Polio
- o Rheumatic fever
- o Scarlet fever
- o Sexually transmitted disease
- o Stroke
- o Tuberculosis
- o Typhoid fever
- o Ulcer
- o Other:_____

_____

_____

_____

## 2. Operations:

**What type & date:**

_____

_____

_____

_____

_____

## 3. Scans:

- o X – ray
- o CT Scan
- o MRI

**Date:**

_____

_____

_____

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Please check all that apply if you have or have had problems.

_____
Patient Name

## 4. Musculoskeletal

____ Osteoporosis

____ Knee injuries

____ Arthritis

____ Foot/ankle pain

____ Scoliosis

____ Shoulder problems

____ Neck pain

____ Back problems

____ TMJ issues

____ Hip disorders

____ Poor posture

## Neurological

_____ Anxiety

_____ Depression

_____ Headache

_____ Dizziness

_____ Pins and needles

_____ Numbness

## Genitourinary

____ Kidney stones

____ Prostate issues

____ PMS Symptoms

____ Bedwetting

## Cardiovascular

_____ High blood pressure

_____ Low blood pressure

_____ High cholesterol

_____ Poor circulation

_____ Angina

_____ Excessive bruising

## Constitutional

____ Fainting

____ Poor appetite

____ Fatigue

____ Sudden weight loss/gain

## Respiratory

____ Asthma

____ Apnea

____ Emphysema

____ Hay fever

____ Shortness of breath

____ Pneumonia

## Digestive

____ Anorexia/bulimia

____ Ulcer

____ Food sensitivities

____ Heartburn

____ Constipation

____ Diarrhea

## Sensory

____ Blurred vision

____ Ringing in ears

____ Hearing loss

____ Chronic ear infections

____ Loss of smell

____ Loss of taste

## Skin

____ Skin cancer

____ Psoriasis

____ Eczema

____ Acne

____ Hair loss

____ Rash

## Endocrine

____ Thyroid Issues

____ Immune disorders

____ Hypoglycemia

____ Frequent infection

____ Swollen glands

____ Low energy

5. **Prescriptions** (Please provide a copy OR list below all prescription, over-the-counter, natural supplements)

| Name of Medication | Dosage (mg) | How often? | Name of Medication | Dosage (mg) | How often? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

6. **Allergies** – Are you allergic to any medications? _____ Yes _____ No

Name of mediation: _____ Reaction: _____

7. **Do you wear**: Heel lifts Inner Soles Arch Supports None (Please circle all that apply)

8. **Social History**

| | (Circle One) | | |
|---|---|---|---|
| Alcohol use | Yes | No | How much?_____ |
| Coffee Use | Yes | No | How much?_____ |
| Tobacco Use | Yes | No | How much?_____ |
| Exercising | Yes | No | How much?_____ |
| Pain relievers | Yes | No | How much?_____ |
| Soft drink | Yes | No | How much?_____ |
| Water intake | Yes | No | How much?_____ |

Stress/Job pressure?

_____

Hobbies:_____

9. **Family History: Some health issues are hereditary.**

| Relative | Age (if living) | State of Health | Illnesses | Age at Death | Cause of death |
|---|---|---|---|---|---|
| Mother | _____ | Good or Poor | _____ | _____ | Natural or Illness |
| Father | _____ | Good or Poor | _____ | _____ | Natural or Illness |
| Sister 1 | _____ | Good or Poor | _____ | _____ | Natural or Illness |
| Sister 2 | _____ | Good or Poor | _____ | _____ | Natural or Illness |
| Brother 1 | _____ | Good or Poor | _____ | _____ | Natural or Illness |
| Brother 2 | _____ | Good or Poor | _____ | _____ | Natural or Illness |

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_____

Patient Name

## 10. Activities of Daily Living (Please check all that apply)

How does this condition interfere with your life and ability to function?

| | No | Mild | Mod. | Severe |
|---|---|---|---|---|
| Sitting | _____ | _____ | _____ | _____ |
| Rising out of chair | _____ | _____ | _____ | _____ |
| Standing | _____ | _____ | _____ | _____ |
| Walking | _____ | _____ | _____ | _____ |
| Lying down | _____ | _____ | _____ | _____ |
| Bending over | _____ | _____ | _____ | _____ |
| Climbing stairs | _____ | _____ | _____ | _____ |
| Driving a car | _____ | _____ | _____ | _____ |
| Concentrating | _____ | _____ | _____ | _____ |

| | No | Mild | Mod. | Severe |
|---|---|---|---|---|
| Grocery shopping | _____ | _____ | _____ | _____ |
| Household chores | _____ | _____ | _____ | _____ |
| Lifting objects | _____ | _____ | _____ | _____ |
| Reaching overhead | _____ | _____ | _____ | _____ |
| Showering or bathing | _____ | _____ | _____ | _____ |
| Dressing myself | _____ | _____ | _____ | _____ |
| Getting to sleep | _____ | _____ | _____ | _____ |
| Staying asleep | _____ | _____ | _____ | _____ |
| Exercising | _____ | _____ | _____ | _____ |

## Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement & initial.

Initials ____ I instruct the chiropractor to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials____ I grant permission to be called to confirm or reschedule an appointment, or questions regarding insurance or payment and to be sent occasional cards, letters, or health information to me as an extension of my care in this office.

Initials____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or **non-covered services I receive.**

Initials____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient (or Guardian's signature) Date