Outten Chiropractic - Patient Profile

Full Name: Last: _____ First: _____ M.I: _____

Address: Street Address: _____ Apartment/Unit # _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____H / M / B Alternate Phone:_____ H / M / B

Birth Date: ____/____/____ Social Security Number #:_____ -____ -_____ Gender: ❑Male ❑Female

Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American
❑Native Hawaiian or Other Pacific Islander ❑White ❑Declined ❑Unknown/Unavailable
❑Other:_____

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Declined ❑Unknown/Unavailable

Primary Language: ❑Arabic ❑Chinese ❑English ❑French ❑German ❑Greek
❑Hebrew ❑Italian ❑Japanese ❑Korean ❑Spanish ❑Vietnamese
❑Declined ❑Unknown/Unavailable ❑Other:_____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Do you have any dependents? ❑Yes ❑No

Are you a full-time student? ❑Yes ❑No

Health Insurance? ❑Yes ❑No

Responsible Party: ❑You ❑Other (parent, spouse, etc.):_____

Primary Care Physician:

Physican Name: _____

Address: Street Address: _____ Apartment/Unit # _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Employer Information:

Your Employment Status: ❑Full Time ❑Part Time ❑Contract ❑Not Employed ❑Retired ❑Student

Occupation or Title: _____

Employer Name: _____

Emplyer Address: Street Address: _____ Apartment/Unit # _____

City: _____ State: _____ Zip Code: _____

Employer Phone: _____Ext._____ Fax: _____

Start Date:____/____/____ End Date: (If you are no longer working here.) ____/____/_____

Throughout the day do you primary: ❑Sit ❑Stand ❑Both

Hobbies: _____

Patient (or guardian) Signature: _____ Date:_____

Outten Chiropractic - Current Complaints

Name: _____ DOB: _____ Date:_____

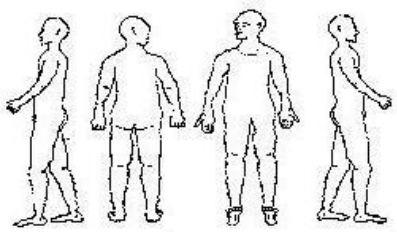
Your current concern(s):

❑Headaches ❑Neck pain ❑Low back pain ❑Mid back pain ❑Shoulder pain ❑Elbow pain ❑Hip pain ❑Knee pain ❑Other concerns:_____

When did your symptoms begin?

If unknown please estimate: _____

Mark the areas of your pain below:



[Female Patients] Are you pregnant? ❑Yes ❑No

If yes, estimate your due date: _____

If no, date of most recent menstrual cycle: _____

Which word best describes the frequency of your symptoms:

❑Occasional (0-25%) ❑Intermittent (26-50%) ❑Frequent (51-75%) ❑Constant (75-100%)

Which phrases best describe changes in your symptoms during the day? (select all that apply)

❑Worse in the morning ❑Worse in the afternoon ❑Worse at night ❑Changes with the weather ❑Does not change

What helps to relieve your symptoms? (select all that apply)

❑Ice ❑Heat ❑Medication ❑Physical therapy ❑Acupuncture ❑Massage
❑Nothing ❑Other relief: _____

What activities are limited by your symptoms? (select all that apply)

❑Bending ❑Bowel movement ❑Coughing ❑Daily routine ❑Driving ❑Getting up
❑Lifting ❑Lying down ❑Pulling ❑Pushing ❑Reading ❑Sitting
❑Sleeping ❑Sneezing ❑Standing ❑Turning head ❑Urination ❑Walking
❑Working ❑Other activities: _____

Date of your last Physical Exam:_____ Date of your last Spinal x-ray:_____ Date of your last MRI: _____

Date of your last CT scan:_____ Date of your last Dental x-rays:_____ Date of any other scan and description:_____

PRIOR TREATMENT

Have you tried other medical treatments for this condition? ❑Yes ❑No

Specify treatment provider:

❑Hospital or Urgent care ❑Medical Physician ❑Chiropractor ❑Massage Therapist ❑Physical Therapist
❑Acupuncturist ❑Other treatment provider:_____

Start date of prior treatment:_____ End date of prior treatment: _____

This office requires a copy of the medical report detailing your treatment:

❑I will provide a copy ❑I will fax it ❑I will e-mail it ❑I will sign an authorization for my records to be released.

Are you symptoms the result of an auto accident or workers compensation case? ❑Yes ❑No

Patient (or Guardian) Signature: _____ Date: _____

Outten Chiropractic

Health History Form

Patient Name: _____ DOB:_____ Date:_____

Prescription medication, over-the-counter medication, vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Medication: _____ Dosage:_____ Frequency: per ❑Day ❑Week ❑Month ❑Other

Medication: _____ Dosage:_____ Frequency: per ❑Day ❑Week ❑Month ❑Other

Medication: _____ Dosage:_____ Frequency: per ❑Day ❑Week ❑Month ❑Other

Medication: _____ Dosage:_____ Frequency: per ❑Day ❑Week ❑Month ❑Other

Medication: _____ Dosage:_____ Frequency: per ❑Day ❑Week ❑Month ❑Other

Diet and Exercise:

Check if you have ever smoked cigars or cigarettes. ❑Yes

Check if you still smoke. ❑Yes

How much do you smoke? ❑Less than one pack per week ❑1-2 packs per week

❑1 pack every two days ❑1 pack per day ❑More than one pack per day

Check if you drink alcoholic beverages. ❑Yes

How many alcoholic beverages do you consume per week? _____

Check if a physician has ever diagnosed you as an alcoholic. ❑Yes

Check if a physician has ever diagnosed you with any liver-related problems. ❑Yes

Check if you exercise regularly. ❑Yes

How many days do you exercise each week? _____

Allergies:

Check if a physician has ever diagnosed you with any allergies. ❑Yes

Do you have Airborne allergies? ❑Yes

❑Animal ❑Molds/Fungus ❑Pollens ❑Cat Hair ❑Cockroach ❑Dog Hair
❑Feather Mix ❑Guinea Pig Hair ❑Dust Mites ❑Other: _____

Do you have Chemical allergies? ❑Yes

❑Acetone ❑Acetylcholine ❑Auto Exhaust ❑Benzyl Alcohol ❑Chlorine ❑Citric Acid
❑Cologne (all) ❑Diesel Exhaust ❑Dopamine ❑Estradiol ❑Ethanol ❑Fluorine
❑Formaldehyde ❑Latex ❑Melatonin ❑Newspaper Print ❑Norepinephrine ❑Progesterone
❑Propylene ❑Serotonin ❑Silicone Implant ❑Sponge Rubber ❑Toluene ❑Trichloroethylene
❑Wood Pulp ❑Xylene ❑Other: _____

Do you have Drug allergies? ❑Yes

❑Anticonvulsants ❑Codeine ❑Insulin Preparations ❑Iodine ❑Morphine ❑Novocain
❑Penicillin ❑Sulfa ❑Other: _____

Do you have Food allergies? ❑Yes

❑Artificial Colorings ❑Artificial Flavoring ❑ Beef ❑Coffee/Tea ❑Dairy ❑Eggs
❑Fish/Shellfish ❑Fruits ❑Lamb ❑Nuts ❑Pork ❑Poultry
❑Vegetables ❑Other: _____

Surgical History:

Check if you have any implants, screws, plates or other foreign objects in your body. ❑Yes

❑Bullet Wound(s) ❑Infusion Catheter ❑Ear Implant ❑Pacemakers ❑Eye Implant ❑Brain Plate(s)
❑Heart Valve(s) ❑Shrapnel ❑Other: _____

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

❑Ankle Year(s) of surgery: _____ ❑Head Year(s) of surgery: _____

❑Back Year(s) of surgery: _____ ❑Hip Year(s) of surgery: _____

❑Cosmetic or Augmentation Year(s) of surgery: _____ ❑Knee Year(s) of surgery: _____

❑Elbow Year(s) of surgery: _____ ❑Neck Year(s) of surgery: _____

❑Foot Year(s) of surgery: _____ ❑Shoulder Year(s) of surgery: _____

❑Hand Year(s) of surgery: _____ ❑Wrist Year(s) of surgery: _____

❑Other Please describe: _____ Year(s) of surgery: _____

Organ System Surgeries (Check if you have had any of the following surgeries)

❑Brain Year(s) of surgery: _____ ❑Intestine,large Year(s) of surgery: _____

❑Colon Year(s) of surgery: _____ ❑Liver Year(s) of surgery: _____

❑Esophagus Year(s) of surgery: _____ ❑Lung Year(s) of surgery: _____

❑Eye Year(s) of surgery: _____ ❑Mastectomy Year(s) of surgery: _____

❑Heart Year(s) of surgery: _____ ❑Reproductive Organs Year(s) of surgery: _____

❑Kidney Year(s) of surgery: _____ ❑Skin Year(s) of surgery: _____

❑Intestine, small Year(s) of surgery: _____ ❑Throat Year(s) of surgery: _____

❑Other Please describe: _____ Year(s) of surgery: _____

❑Transplant Please describe: _____ Year(s) of surgery: _____

Your Cancer History:

Check if a physician has ever diagnosed you with cancer. ❑Yes

Check all that apply

❑Bladder ❑Lung ❑Brain ❑Non-Hodgkin's Lymphoma ❑Breast
❑Ovarian ❑Cervical ❑Pancreatic ❑Colon or Rectal ❑Prostate ❑Endometrial
❑Skin ❑Eye ❑Basal Cell Carcinoma ❑Kidney (renal cell)
❑Squamous Cell Carcinoma ❑Leukemia ❑Melanoma ❑Stomach ❑Thyroid
❑Uterine ❑Other: _____

Family Cancer History:

Check if a physician has ever diagnosed your family with cancer. ❑Yes

Check all that apply and the family member(s) who had this condition:

❑Bladder (M, F, S, MG, PG) ❑Lung (M, F, S, MG, PG) ❑Brain (M, F, S, MG, PG)
❑Non-Hodgkin's Lymphoma (M, F, S, MG, PG) ❑Breast (M, F, S, MG, PG)
❑Ovarian (M, F, S, MG, PG) ❑Cervical (M, F, S, MG, PG) ❑Pancreatic (M, F, S, MG, PG)
❑Colon or Rectal (M, F, S, MG, PG) ❑Prostate (M, F, S, MG, PG) ❑Endometrial (M, F, S, MG, PG)
❑Skin (M, F, S, MG, PG) ❑Eye (M, F, S, MG, PG) ❑Basal Cell Carcinoma (M, F, S, MG, PG)
❑Kidney (renal cell) (M, F, S, MG, PG) ❑Squamous Cell Carcinoma (M, F, S, MG, PG)
❑Leukemia (M, F, S, MG, PG) ❑Melanoma (M, F, S, MG, PG) ❑Stomach (M, F, S, MG, PG)
❑Thyroid (M, F, S, MG, PG) ❑Uterine (M, F, S, MG, PG) ❑Other:_____(M , F , S, MG, PG)

Your Cardio-Pulmonary / Circulatory Health:

Check if a physician has ever diagnosed you with any of the following:

❑Anemia ❑HIV/AIDS ❑Hemophilia ❑Hepatitis ❑Hypertension (high blood pressure)
❑Hypotension (low blood pressure) ❑Hemorrhoids ❑Lung Disorders ❑Acute Respiratory Distress Syndrome
❑Alpha-1 Antitrypsin Deficiency ❑Asbestos/Dust Disease ❑Asthma ❑Bronchiectasis
❑Bronchitis (chronic) ❑Bronchopulmonary Dysplasia (BPD) ❑Chronic Obstructive Pulmonary Disease ❑Cystic Fibrosis
❑Emphysema ❑Farmer's Lung ❑Hantavirus ❑Histoplasmosis ❑Legionellosis
❑Lymphangioleiomyomatosis ❑Pleurisy ❑Pneumonia ❑Pneumothorax ❑Primary Alveolar Hypoventilation Syndrome ❑Pulmonary Alveolar Proteinosis ❑Pulmonary Embolus ❑Pulmonary Fibrosis
❑Respiratory Distress Syndrome ❑Respiratory Syncytial Virus ❑Sarcoidosis ❑Severe Acute Respiratory Syndrome ❑Spontaneous Pneumothorax ❑Tuberculosis ❑Raynaud's Phenomenon ❑Sickle Cell Anemia ❑Sinus Infections (chronic) ❑Stroke ❑Wegener's Granulomatosis ❑Other:
_____

Family Cardio-Pulmonary / Circulatory Health:

Check if a physician has ever diagnosed your family with any of the following:

❑Anemia *(M, F, S, MG, PG)* ❑HIV/AIDS *(M, F, S, MG, PG)* ❑Hemophilia *(M, F, S, MG, PG)*
❑Hepatitis *(M, F, S, MG, PG)* ❑Hypertension (high blood pressure) *(M, F, S, MG, PG)*
❑Hypotension (low blood pressure) *(M, F, S, MG, PG)* ❑Hemorrhoids *(M, F, S, MG, PG)*
❑Lung Disorders *(M, F, S, MG, PG)* ❑Acute Respiratory Distress Syndrome *(M, F, S, MG, PG)*
❑Alpha-1 Antitrypsin Deficiency *(M, F, S, MG, PG)* ❑Asbestos/Dust Disease *(M, F, S, MG, PG)*
❑Asthma *(M, F, S, MG, PG)* ❑Bronchiectasis *(M, F, S, MG, PG)* ❑Bronchitis (chronic) *(M, F, S, MG, PG)*
❑Bronchopulmonary Dysplasia(BPD) *(M, F, S, MG, PG)* ❑Chronic Obstructive Pulmonary Disease *(M, F, S, MG, PG)*
❑Cystic Fibrosis *(M, F, S, MG, PG)* ❑Emphysema *(M, F, S, MG, PG)* ❑Farmer's Lung *(M, F, S, MG, PG)*
❑Hantavirus *(M, F, S, MG, PG)* ❑Histoplasmosis *(M, F, S, MG, PG)* ❑Legionellosis *(M, F, S, MG, PG)*
❑Lymphangioleiomyomatosis *(M, F, S, MG, PG)* ❑Pleurisy *(M, F, S, MG, PG)*
❑Pneumonia *(M, F, S, MG, PG)* ❑Pneumothorax *(M, F, S, MG, PG)* ❑Primary Alveolar Hypoventilation Syndrome *(M, F, S, MG, PG)* ❑Pulmonary Alveolar Proteinosis *(M, F, S, MG, PG)* ❑Pulmonary Embolus *(M, F, S, MG, PG)* ❑Pulmonary Fibrosis *(M, F, S, MG, PG)* ❑Respiratory Distress Syndrome *(M, F, S, MG, PG)* ❑Respiratory Syncytial Virus *(M, F, S, MG, PG)* ❑Sarcoidosis *(M, F, S, MG, PG)*

❑Severe Acute Respiratory Syndrome *(M, F, S, MG, PG)* ❑Spontaneous Pneumothorax *(M, F, S, MG, PG)*
❑Tuberculosis *(M, F, S, MG, PG)* ❑Raynaud's Phenomenon *(M, F, S, MG, PG)*
❑Sickle Cell Anemia *(M, F, S, MG, PG)* ❑Sinus Infections (chronic) *(M, F, S, MG, PG)*
❑Stroke *(M, F, S, MG, PG)* ❑Wegener's Granulomatosis *(M, F, S, MG, PG)*
❑Other: _____ *(M, F, S, MG, PG)*

Endocrine, Gastrointestinal and Neurologic Health:

Check if a physician has ever diagnosed you with any of the following:

❑Autoimmune Disorder: ❑Dermatitis ❑Churg-Strauss (Allergic Granulomatosis)
❑Eosinophilic Fasciitis ❑Dermatomyositis/Polymyositis ❑Goodpasture's Syndrome
❑Interstitial Granulomatous Dermatitis with Arthritis ❑Lupus: ❑Lupus SLE ❑Lupus DLE ❑Lupus SCLE
❑Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant) ❑Mixed Connective Tissue Disease
❑Relapsing Polychondritis ❑Rheumatoid Arthritis ❑Sarcoidosis ❑Scleroderma
❑Sjogren's Syndrome ❑Skin Immunofluorescence ❑Vasculitis ❑Bladder Disease
❑Candida ❑Chicken Pox ❑Chronic Fatigue Syndrome ❑Crohn's Disease ❑Diabetes
❑Epilepsy ❑Fibromyalgia ❑Gall Bladder Problems ❑Headaches ❑Cluster Headaches
❑Migraine Headaches ❑Sinus Headaches ❑Stress-induced Headaches ❑Tension Headaches
❑Incontinence ❑Irritable Bowel Syndrome (IBS) ❑Kidney Disease ❑Liver Disease ❑Liver Problems
❑Measles ❑Mumps ❑Seizures ❑Shingles ❑Stomach Ulcers ❑Thyroid Dysfunction
❑Urinary Tract Infection ❑Other: _____

Emotional and Mental Health:

Check if a physician has ever diagnosed you with an emotional or mental condition. ❑Yes

❑Anger Disorders ❑Anxiety Disorders ❑Asperger Syndrome ❑Attention Deficit Disorder with Hyperactivity (ADHD) ❑Autistic Disorder ❑Avoidant Personality Disorder (AvPD) ❑Bipolar Disorder
❑Borderline Personality Disorder ❑Capgras Syndrome ❑Child Behavior Disorders ❑Combat Disorders
❑Cyclothymic Disorder ❑Dependent Personality Disorder (DPD) ❑Depressive Disorders (depression)
❑Dissociative Disorders ❑Dysthymic Disorders (mood disorder) ❑Eating Disorders ❑Firesetting Behavior
❑Hypochondriasis (Somatoform Disorder) ❑Impulse Control Disorders ❑Kleine-Levin Syndrome ❑Kleptomania
❑Multiple Personality Disorder ❑Munchhausen Syndrome ❑Narcissistic Personality Disorder
❑Narcolepsy ❑Obsessive Compulsive Disorder (OCD) ❑Phobic Disorders (Phobias) ❑Psychotic Disorders
❑Restless Legs Syndrome ❑Schizophrenia ❑Seasonal Affective Disorder
❑Sexual or Gender Disorders ❑Sexual Dysfunctions (psychological, not physical) ❑Sleep Disorders
❑Post-traumatic Stress Syndrome ❑Substance Abuse ❑Suicidal Tendencies
❑Other: _____

Sensory Health:

Check if a physician has ever diagnosed you with any of the following:

❑Blindness ❑Cataract ❑Cholesteatoma ❑Deafness or Hearing Loss ❑Ear ringing
❑Eczema ❑Glaucoma ❑Laryngitis (chronic) ❑Macular Degeneration
❑Mumps ❑Meniere's Disease ❑Nasal Polyps ❑Perforated Eardrum ❑Psoriasis
❑Rhinitis ❑Sinusitis ❑Tinnitus ❑Unusual Vision Impairment ❑Vertigo
❑Other: _____

Musculoskeletal Health:

Check if a physician has ever diagnosed you with any of the following:

❑Arthritis ❑Ankylosing Spondylitis ❑Behets Disease ❑Carpal Tunnel Syndrome
❑Diffuse Idiopathic Skeletal Hyperostosis (DISH) ❑Ehlers-Danlos Syndrome (EDS) ❑Felty's Syndrome
❑Fibromyalgia ❑Infectious Arthritis ❑Mixed Connective Tissue Disease (MCTD)
❑Osteoarthritis ❑Osteoporosis ❑Paget's Disease ❑Polymyalgia Rheumatica
❑Polymyositis and Dermatomyositis ❑Pseudogout ❑Psoriatic Arthritis ❑Reactive Arthritis
❑Repetitive Stress Injury ❑Rheumatoid Arthritis ❑Scleroderma ❑Sjogren's Syndrome
❑Stills Disease ❑Gout ❑Herniated Disk ❑Lyme Disease ❑Multiple Sclerosis
❑Muscular Dystrophy ❑Numbness or Tingling in feet ❑Numbness or Tingling in hands
❑Osteoporosis ❑Parkinson's Disease ❑Pinched Nerve ❑Polio ❑Rheumatism
❑Sciatica ❑Temporomandibular Joint Syndrome (TMJ) ❑Other: _____

Reproductive Health:

Check if you have ever given birth. ❑Yes

How many births vaginally? _____

How many births by C-section? _____

Check if a physician has ever diagnosed you with any of the following:

❑Chlamydia ❑Dysplasia ❑Erectile Dysfunction ❑Genital Herpes ❑Gonorrhea
❑Human Papillomavirus (HPV) ❑Impotency ❑Syphilis ❑Infertility ❑Cystitis
❑Menopause ❑Prostate Enlargement ❑Testicular Dysfunction ❑Uterine Fibroid
❑Vaginal Yeast Infections (chronic) ❑Other: _____

Patient (or Guardian) Signature:_____ Date: _____