

Welcome to Midlands Health Center

We want to take this opportunity to welcome you to our practice!

Our goal is to make your visit here as pleasant and as efficient as possible.

*Please take a moment to complete the following
so that we may better serve you and your family.*

PATIENT INFORMATION

Full name: Mr. Mrs. Ms. _____
Mailing address: _____
Home phone: () _____ Work phone: () _____ Mobile phone: () _____
SS#: _____ Age: _____ DOB: / / e-mail: _____
Marital status: Married Single Separated Divorced Widowed Number of children: _____
Employer's name: _____
Employer's address: _____
Spouse's name and address (if different): _____
Spouse's DOB: / / SS#: _____ Spouse's work phone: () _____
Spouse's employer's name: _____
Spouse's employer's address: _____
Emergency contact (not living with you): _____ Home phone: () _____
Relationship: _____ Work phone: () _____

IF THE PATIENT IS A CHILD OR FULL-TIME STUDENT, PLEASE COMPLETE

Mother's name: _____ SS#: _____ DOB: / /
Address (if different): _____ Home phone: () _____
Mother's employer's name: _____ Work phone: () _____
Mother's employer's address: _____
Father's name: _____ SS#: _____ DOB: / /
Address (if different): _____ Home phone: () _____
Father's employer's name: _____ Work phone: () _____
Father's employer's address: _____

MEDICAL INFORMATION

Referred by: _____ Address: _____
Primary care doctor: _____
Primary care doctor's address: _____
How did you learn about us? _____

HISTORY OF PRESENT ILLNESS

What problem(s) brought you in to the doctor today? *Check all that apply.*

	Date of onset	Right/Left	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head									
Neck									
Upper back									
Mid-back									
Lower back									
Shoulder									
Arm									
Forearm									
Wrist									
Hand									
Ribs									
Buttock									
Hip									
Thigh									
Leg									
Knee									
Ankle									
Foot									

Which is your chief concern? _____

How severe is the pain on a scale of 0 to 10 with 0 being none and 10 being the worst pain imaginable?

Circle one 0 1 2 3 4 5 6 7 8 9 10

Have you been seen or treated for this problem before? Yes No

If yes, by whom? _____

What treatments have you had? None Medicine Physical therapy Surgery
 Other _____

Did any of these treatments help? Yes Yes, but it came back Partially
 No

Have you had anything like this in the past? Yes No Not sure

Other concerns: _____

MEDICAL ILLNESSES

Do you have presently or have you ever been diagnosed with any of these diseases?

- | | | | |
|--|---|--|--------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stomach disorder | <input type="checkbox"/> Blood clots in legs | Others |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Back/disc problems | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Neck problems | <input type="checkbox"/> Thyroid disease | _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Kidney disease | _____ |
| <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Pinched nerve in spine | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine/headaches | <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | _____ |

Please list and explain any SURGICAL OPERATIONS and approximate dates

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list and explain any HOSPITALIZATIONS and approximate dates

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list and explain any PAST TRAUMA and approximate dates

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list and explain any PAST CHIROPRACTIC CARE and approximate dates

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Immunization History (please record the year the vaccine was last given)

- | | |
|-------------------|---|
| _____ Tetanus | _____ Pneumovax (pneumonia vaccination) |
| _____ MMR | _____ Influenza |
| _____ Hepatitis A | _____ Hepatitis B |
| _____ Hepatitis C | |

FAMILY HISTORY

Do any immediate family members (parents, siblings, or children) suffer from the following?

Disease	Family member	Disease	Family member
Back/Disc disease		Heart attack	
Neck problems/arthritis		Coronary artery disease	
Osteoporosis		Congestive heart failure	
Scoliosis		High blood pressure	
Pinched nerve in spine		Stroke/CVA/TIA	
Cancer		Peripheral artery disease	
Migraine/headache		Diabetes	
Osteoarthritis		Kidney disease	
Rheumatoid arthritis		Thyroid disease	
Connective tissue disease		Digestive disorder	

MEDICATIONS

Prescription medications

Dosage (e.g. mg)

How often do you take it?

What is it for?

Over-the-counter medications

Dosage (e.g. mg)

How often do you take it?

What is it for?

Nutritional supplements

Dosage (e.g. mg)

How often do you take it?

What is it for?

ALLERGIES TO MEDICATIONS

Medication

Allergic reaction

No known allergies to medications

SOCIAL HISTORY

Do you drink caffeine?

No Yes

If yes, how much?

How often?

Do you drink alcohol?

No Yes

If yes, how much?

How often?

Do you smoke?

No Yes

If yes, how much?

How often?

Do you exercise?

No Yes

If yes, how much?

How often?

Do you suffer from substance abuse?

No Yes

If yes, what substances?

What sports do you participate in?

What are your hobbies?

WORK HISTORY

What is your occupation?

Full-time Part-time

Does your present complaint affect the number of hours you work per day? No Yes

Job duties include:

Lifting (_____ pounds)

Bending

Stooping

Carrying

Twisting

Walking

Turning

Other: _____

What is your primary work position?

Seated

Counter

Standing

Desk

Other: _____

What is your dominant hand? Right-handed Left-handed Ambidextrous

Which of the following best describes your stress level?

None

Minimal

Moderate

High

How do you rate your physical activity at work?

Seated more than 50 percent of your day

Light manual labor

Moderate manual labor

Heavy manual labor

ACTIVITIES

Which activities aggravate your condition?

Vacuuming/cleaning

Dishwashing

Laundry

Shopping

Caring for family

Carrying groceries/bags

Grooming

Bathing

Dressing

Eating

Moving your bowels

Reading

Using the telephone

Other: _____

REVIEW OF SYSTEMS

Please check all that apply:

General

- | | | |
|--------------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chills | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Night sweats | |

Eyes

- | | | | |
|--|---|-----------------------------------|---|
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Eye redness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye pain | |

Ears, Nose, Mouth, Throat

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Bloody nose | <input type="checkbox"/> Mouth pain | <input type="checkbox"/> Swollen throat |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Ringing in your ears | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Throat pain |
| <input type="checkbox"/> Spinning/dizziness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Hoarseness |
| | <input type="checkbox"/> Itchy nose | <input type="checkbox"/> Tongue changes | |

Cardiovascular

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain while walking | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Shortness of breath while lying down |

Respiratory

- | | | | |
|---|---------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sputum |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Tuberculosis | | |

Gastrointestinal

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Black stools | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cramping | <input type="checkbox"/> Passing of mucus | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Anal pain/itching |
| <input type="checkbox"/> Heartburn | | <input type="checkbox"/> Change of bowel habits | |

Genitourinary

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Impotence | <input type="checkbox"/> Menstruation change |
| <input type="checkbox"/> Increase frequency in urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Genital soreness | |
| <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> STD/VD | |

Musculoskeletal

- | | | |
|---------------------------------------|--|-------------------------------|
| <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Joint aches | <input type="checkbox"/> Joint swelling | |

Skin

- | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Mole changes | <input type="checkbox"/> Hair changes |
| <input type="checkbox"/> Skin itching | <input type="checkbox"/> Dryness | <input type="checkbox"/> Nail changes |

Neurological

- | | | | |
|--------------------------------------|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Confusion | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tingling | |

Psychiatric

- | | | |
|-------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anxiety |
|-------------------------------------|-----------------------------------|----------------------------------|

Endocrine

- | | | | |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Neck swelling |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Excessive hunger | |

Lymphatic, Blood

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Lymph node swelling | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Transfusions | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Anemia | | | |

Allergies

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Skin sensitivities | <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Food allergies |
|---|--|--|---|

FEMALE ONLY — PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time:

I am sure that I am not pregnant. It is possible that I could be pregnant. I am pregnant.

Patient signature _____
MM/DD/YY

Witness signature _____
MM/DD/YY

PERSONAL INJURY

Is your condition due to:

Automobile accident? Yes No

Injury at work? Yes No

Date of injury: _____

Attorney name: _____

Attorney phone number: () _____

INSURANCE INFORMATION

Primary insurance name: _____ Effective date: _____
Name of insured: _____ ID#: _____ Group #: _____
Insurance claim address: _____
City: _____ State: _____ ZIP: _____ Phone number: _____
Employer of insured: _____ DOB of insured: _____
Patient's relationship to insured: Self Spouse Child Other MM/DD/YY

Secondary insurance name: _____ Effective date: _____
Name of insured: _____ ID#: _____ Group #: _____
Insurance claim address: _____
City: _____ State: _____ ZIP: _____ Phone number: _____
Employer of insured: _____ DOB of insured: _____
Patient's relationship to insured: Self Spouse Child Other MM/DD/YY

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that should I personally receive an insurance check for services rendered at Midlands Health Center, I will bring the check and the accompanying explanation of benefits to the office so that it can be posted to my account. I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of said problems.

Patient name printed: _____

Patient signature: _____ Date: _____

Today I will be paying by (PLEASE CIRCLE ONE)

Cash Check Visa/MC/Discover