**Health/ Medical History**

**What treatment have you already received?** □ Medications □ Surgery □ Physical Therapy

□ Chiropractic services □ None □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name & address of other doctor(s) that have treated you for your condition(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last:** Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spinal X-Ray: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Spinal Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chest X-Ray: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Urine Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dental X-Ray: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRI, CT-Scan, Bone Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place a mark on “Yes” or “No” to indicate if you have had any of the following:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AIDS/ HIV** | □ Yes | □ No | **Alcoholism** | □ Yes | □ No | **Allergy Shots** | □ Yes | □ No |
| **Anemia** | □ Yes | □ No | **Anorexia** | □ Yes | □ No | **Appendicitis** | □ Yes | □ No |
| **Arthritis** | □ Yes | □ No | **Asthma** | □ Yes | □ No | **Bleeding Disorders** | □ Yes | □ No |
| **Breast Lump** | □ Yes | □ No | **Bronchitis** | □ Yes | □ No | **Bulimia** | □ Yes | □ No |
| **Cancer** | □ Yes | □ No | **Cataracts** | □ Yes | □ No | **Chemical Dependency** | □ Yes | □ No |
| **Chicken Pox** | □ Yes | □ No | **Diabetes** | □ Yes | □ No | **Emphysema** | □ Yes | □ No |
| **Epilepsy** | □ Yes | □ No | **Fractures** | □ Yes | □ No | **Glaucoma** | □ Yes | □ No |
| **Goiter** | □ Yes | □ No | **Gonorrhea** | □ Yes | □ No | **Gout** | □ Yes | □ No |
| **Heart Disease** | □ Yes | □ No | **Hepatitis** | □ Yes | □ No | **Hernia** | □ Yes | □ No |
| **Herniated Disc** | □ Yes | □ No | **Herpes** | □ Yes | □ No | **High Cholesterol** | □ Yes | □ No |
| **Kidney Disease** | □ Yes | □ No | **Liver Disease** | □ Yes | □ No | **Measles** | □ Yes | □ No |
| **Migraine Headaches** | □ Yes | □ No | **Miscarriage** | □ Yes | □ No | **Mononucleosis** | □ Yes | □ No |
| **Multiple Sclerosis** | □ Yes | □ No | **Mumps** | □ Yes | □ No | **Osteoporosis** | □ Yes | □ No |
| **Pacemaker** | □ Yes | □ No | **Parkinson’s Disease** | □ Yes | □ No | **Pinched Nerve** | □ Yes | □ No |
| **Pneumonia** | □ Yes | □ No | **Polio** | □ Yes | □ No | **Prostate problems** | □ Yes | □ No |
| **Prosthesis** | □ Yes | □ No | **Psychiatric Care** | □ Yes | □ No | **Rheumatoid Arthritis** | □ Yes | □ No |
| **Rheumatic Fever** | □ Yes | □ No | **Scarlet Fever** | □ Yes | □ No | **Stroke** | □ Yes | □ No |
| **Suicide Attempt** | □ Yes | □ No | **Thyroid Problems** | □ Yes | □ No | **Tonsillitis** | □ Yes | □ No |
| **Tuberculosis** | □ Yes | □ No | **Tumors, Growths** | □ Yes | □ No | **Typhoid Fever** | □ Yes | □ No |
| **Ulcers** | □ Yes | □ No | **Vaginal Infections** | □ Yes | □ No | **Whooping Cough** | □ Yes | □ No |
| **Other** | □ Yes | □ No |  |  |  |  |  |  |

**Exercise Work Activity Habits**

□ None □ Sitting □ Smoking Packs/ Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Moderate □ Standing □ Alcohol Drinks/ Week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Daily □ Light labor □ Caffeinated Drinks Cups/ Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Heavy □ Heavy Labor □ High Stress Level Reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant** □ Yes □ No Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Injuries/ Surgeries you have had: Description: Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications/ Vitamins:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Reverification Date: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

 **Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Information**

(PLEASE PRINT)

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State:\_\_\_\_\_\_\_  Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_lbs.       Height: \_\_\_\_’\_\_\_\_”  Sex:       ⃞  M       ⃞  F

Birthdate: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_        Age: \_\_\_\_\_\_\_\_\_\_\_  SS# \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Student Status:           ⃞ Full Time   ⃞ Part Time ⃞ Non-student

Relationship Status:     ⃞ Single         ⃞  Married ⃞ Widowed

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Birthdate: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Spouse’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION:**

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_     Work Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_    Cell Phone: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_

Best time & place to reach you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Confirmation Preference (please circle one): Text Email Phone Call

**EMERGENCY CONTACT:**
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_



**Is this condition due to a work injury or auto accident? (Please circle.) YES / NO**

**CONDITION**

\*Mark an X on the picture where you continue to have pain, numbness, or tingling.

Reason for Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms appear?\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate the severity of your pain 1 (least pain) to 10 (severe pain) \_\_\_\_

Is this condition getting progressively worse?  (Please circle) YES / NO

How often do you have this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with your (please circle):   Work  /  Sleep  /  Daily Routine / Recreation

Activities or movements that are painful to perform (please circle):

Sitting / Standing / Walking / Bending / Lying Down

**HIPPA PRIVACY & PRIMARY DOCTOR’S INFORMATION**

\*I have received a copy of the “Notice of Privacy Practices” provided to me by Capitol Rehab of Winchester. PLLC.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Capitol Rehab of Winchester, PLLC may discuss my medical condition and/or information with the following:

1. Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.    Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

      Phone Number: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_